EXHIBIT D

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF KERN

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COLLEEN M. PERRY, Plaintiff, vs. HUNG T. LUU, M.D.; JOHNSON & JOHNSON, a New Jersey corporation; ETHICON, INC., a New Jersey corporation; and DOES 1-60, Defendants.	No. 1500-cv-27912 LHB

DEPOSITION OF TERI A. LONGACRE, M.D.

DATE: December 19, 2014

TIME: 9:00 a.m.

LOCATION: THE STANFORD TERRACE INN
531 Stanford Avenue
Palo Alto, CA 94306

REPORTED BY: LISA R. KEELING
Certified Shorthand Reporter
License No. 10518

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TERI A. LONGACRE, M.D.,

the Witness herein, having been duly and regularly sworn by the Certified Shorthand Reporter, deposed and testified as follows:

EXAMINATION BY MR. JONES

MR. JONES: Q. Good morning, Doctor.

A. Good morning.

Q. You've been retained by Ethicon's law firm to give opinions in this case, correct?

A. Correct.

Q. And are you here today to discuss those opinions?

A. Yes, I am.

Q. Are you here today to discuss the bases for those opinions?

A. Yes, I am.

Q. And you understand this is the plaintiff's opportunity to ask you questions about your opinions and the bases of those opinions?

A. Yes, I do.

Q. Are you prepared to give all of your opinions and the bases for those opinions today?

A. Yes, I am.

Q. I take it you spent some time preparing for your deposition?

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A. Yes, I did.
Q. What did that preparation entail?
A. Review of slides, hospital records, pathology reports, associated literature and discussions with Mr. Snowden predominantly.
Q. Okay. So we have -- I want to break that down. We have slides, right?
A. Correct.
Q. Path reports?
A. Correct.
Q. Relevant medical literature?
A. Yes.
Q. Talked with Mr. Snowden?
A. Correct.
Q. Anything I'm missing?
A. Operative reports, other medical records --
Q. Okay.
A. -- of course, and then there were discussions with some other attorneys, whose names escape me.
Q. Sure. Did you review any deposition testimony?
A. Yes, I did.
Q. Whose deposition testimony did you review?
A. Mrs. Perry's, Mr. Perry's, the -- I'm not sure I know how to pronounce their names, the surgeons.
Q. You reviewed some of the treating physicians' --

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A. Yes, exactly.
Q. -- depositions in this case?
A. Correct. Yes.
Q. Did you review any internal corporate Ethicon documents?
A. I may have reviewed some, yes.
Q. Fair to say that wasn't the focus of your preparation in rendering your opinions in this case?
A. Correct.
Q. The focus was on the pathology records, the pathology slides, relevant medical literature and the treating physicians' depositions?
MR. WES: Object to form.
You can answer.
THE WITNESS: Yes, that's -- that's the focus and then supporting background literature. That's it.
MR. JONES: Q. Okay.
A. That was my --
Q. Did you review any depositions of Ethicon employees?
A. No, I don't think so.
Q. Okay. Did you meet with attorneys prior to today to prepare for your deposition?
A. Yes.
Q. When did you meet with them?

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A. I met with -- yesterday, the day before. I think the last three days.
Q. So you've met with attorneys for three days?
A. Yes.
Q. Who did you meet with?
A. Mr. Snowden.
Q. Okay.
A. And most recently with Mr. --
MR. WES: Mr. Wes.
THE WITNESS: I know his first name, but I didn't know his last name.
MR. JONES: Q. Yeah, sure. When were you first contacted by Ethicon attorneys to work on this particular case?
A. I think it was mid summer of this year.
Q. Mid summer 2014?
A. Yes.
Q. Who contacted you?
A. Mr. Snowden.
Q. Prior to mid summer 2014, did you have any contact with attorneys representing Ethicon?
A. Yes.
Q. When was that?
A. The first part of the year, I believe.
Q. Early 2014?

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A. Yes.
Q. Who contacted you then?
A. Mr. Snowden.
Q. Was that related to this particular case?
A. No.
Q. I take it it was related to another Ethicon case?
MR. WES: Object to form.
THE WITNESS: No.
MR. JONES: Q. What was it related to?
A. It was -- the initial contact was to see if I would be interested in examining or being an expert witness in some of these cases, but there was no specific case at that time.
Q. Okay. So early 2014 Ethicon attorneys contact you to gauge your availability and interest to work on cases involving transvaginal mesh?
A. Correct.
Q. And then in mid summer 2014, Ethicon attorneys contact you, and you agree to work on this particular case?
A. Correct.
Q. Prior to early 2014 had you been contacted by any other attorneys representing Ethicon?
A. No.
Q. Any other attorneys representing any mesh

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manufacturers other than Ethicon?
A. No.
Q. I take it you started your work in this case mid summer 2014 or shortly thereafter?
A. Probably shortly thereafter, yes. Correct.
Q. Maybe late summer 2014 you started to work on this case?
A. That would be correct.
Q. Okay. When did you first start to review the medical records in this case?
A. I believe it was August.
Q. When did you first start to review deposition testimony in this case?
A. It may have been August or September.
Q. Same for relevant medical literature?
A. I had started reviewing some of the medical literature after the January -- or the early -- the first meeting that we had in January or February of the year but nothing that was specifically associated with this case.
Q. Just to get generally familiar with the topics that you would be touching base on?
A. Correct.
Q. Yeah. Are you aware that the device in question in this case is the TVT Abbrevo?
A. Yes.

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Q. Have you seen a TVT Abbrevo device?
A. I've seen mesh that's been removed from the TVT.
Q. Have you seen the TVT Abbrevo device in its package form as it's delivered to surgeons?
A. No.
Q. Have you held the mesh that makes up the TVT Abbrevo device in your own hands?
A. Preplacement? No.
Q. Preplacement?
A. No.
Q. How about postplacement?
A. I think I probably have in the gross room, yes, but just portions of the mesh, not the entire.
Q. What type of mesh is used in the TVT Abbrevo?
A. I'm not sure the question you're asking me.
Q. What is the material that makes up the mesh in the TVT device?
A. Polypropylene.
Q. Do you know how much polypropylene makes up the TVT Abbrevo mesh?
A. No, not at the -- not off the top of my head.
Q. You don't know how long the mesh is in the TVT Abbrevo device prior to implementation?
MR. WES: Object to form.
THE WITNESS: Not off the top of my head.

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MR. JONES: Q. Okay.
A. I read it, but I'm not all that good with numbers.
Q. Sure. You're focused more on the pathology --
A. Correct.
Q. -- aspects?
A. Correct.
Q. Not so much the design features of the TVT Abbrevo device?
A. That's correct, yes.
Q. Do you know -- do you know how the mesh and the TVT Abbrevo device is cut?
MR. WES: Object to form.
THE WITNESS: I'm not sure what you're asking.
MR. JONES: Q. I'll ask a better question.
A. Okay.
Q. Do you know whether the mesh in the TVT Abbrevo device is mechanical cut mesh or laser cut mesh?
A. I believe it's laser.
Q. Okay. Are you familiar with any of the aspects of a laser cut mesh?
MR. WES: Object to form. It's outside the scope.
MR. JONES: Q. Fair to say you're not going to be offering opinions as to the aspects of the laser cut

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mesh device?
A. That would be fair to say, yes.
Q. Okay. Are you familiar with the lightweight large pore concept in mesh surgery?
A. Yes, I --
MR. WES: Object to form, outside the scope.
THE WITNESS: I am familiar with that concept, but that's not -- again, this is not an area that I'm offering an opinion on.
MR. JONES: Q. Perfect. Thank you.
How does tissue inside the vagina react to polypropylene?
MR. WES: Object to form.
THE WITNESS: The tissue response to polypropylene in the vagina is probably not dissimilar to tissue response to polypropylene anywhere in the body. I mean, it made some variations, but generally it's a foreign body reaction.
Q. Okay. There's nothing unique as far as the tissue or inside the vagina that would alter the body's reaction to polypropylene as compared to, say, the stomach?
MR. WES: Object to form.
THE WITNESS: Well, there may be -- vaginal tissue is different than stomach tissue, and so the --

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although the overall foreign body reaction would be the same. The adjacent tissue that it's sort of associated with will be different. I don't know that I'm answering your question.

MR. JONES: Q. Okay.

A. But that's the best I can do.

Q. Sure. I appreciate it. That's probably a bad question.

In the interest of being as efficient as possible with everyone's time here today, did you bring a sheet with the opinions you intend to offer in this case with you today?

A. Yes, I did.

Q. Are you willing to share that sheet --

A. Yes.

Q. -- with me?

A. Yes, I am.

MR. JONES: I'm going to mark the Summary of Opinion of Dr. Teri Longacre as Exhibit L-1.

(Whereupon, Exhibit L-1 was marked for identification.)

MR. JONES: Q. You have a copy of this in front of you, Doctor?

A. Yes. Yes, I do.

Q. Let's go through this Summary of Opinion of

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Dr. Teri Longacre.

What is the first opinion you intend to offer in this case?

A. I don't know that there's necessarily an order of the opinions. As you see I've set forth at the Roman Numeral I just an itemized, I guess, list of what constitutes the inflammatory response and a foreign body response that's associated with implant material, and this really is just by way of making sure that we're all using the same terminology.

So the typical reaction is there may be an acute inflammatory infiltrate, but generally it roughly -- or fairly soon shifts to a more chronic inflammatory infiltrate.

By acute, I mean neutrophils. By chronic, I'm referring to other inflammatory cells. They're usually monocytes which can differentiate into macrophages, lymphocytes, mast cells, et cetera.

Chronic inflammation, the term itself really denotes a description of the cells, not necessarily longstanding. It may be longstanding, but you know, we -- generally we think about chronic being a long-term process.

When you're talking about inflammatory cells, it's a specific type of cell. So I just wanted to make

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that distinction.

Q. Can I stop you right there, Doctor. Do you mind if we switch copies so that you have the copy with the deposition exhibit sticker on it?

A. Sure.

MR. JONES: Is that fine with you, Counsel?

(Counsel did not verbally respond.)

THE WITNESS: Sure. That's fine.

MR. JONES: Thank you. That allows me to mark up this copy without it showing up in the records.

THE WITNESS: Good.

MR. JONES: Q. All right. So before I interrupted you were discussing the acute versus chronic inflammatory reaction.

A. Correct. And the types of cells that you see in acute inflammation versus chronic inflammation.

Q. And is it fair to say then that the first portion under the heading "Inflammatory Response and Foreign Body Response with Implant" is a discussion of the acute versus chronic inflammatory reaction in the cells and some of the terminology that would be applicable in that area?

A. Correct.

Q. And then under letter B you have "Factors impacting wound healing."

What do you intend to talk about related to

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factors impacting wound healing?

A. Well, again, just in general things that can affect how well a wound heals include obviously genetic predisposition, but factors that can prevent wound healing or impair it are lack of nutrition. You need amino acids to heal, protein. Smoking has been shown to impact collagen formation. Diabetes. All of these may have played a role in wound healing in Mrs. Perry.

There are other things that can impact wound healing that I haven't listed. Steroid therapy, et cetera. I don't think that that played a role.

Q. How about genetics? You mentioned genetics. Do you think that played a role in this case?

A. It may or may not.

Q. Okay.

A. Some people heal faster than others. It's variable, so one doesn't really know.

Q. Okay. How about diabetes?

A. Yes, diabetics can have impaired wound healing, and it's all about -- well, it's pretty complex, but it's in part due to vascular insufficiency. You need vascular supplying oxygen to the tissue for adequate wound healing.

And that's, again, sort of why smoking is a risk factor for poor wound healing because smoking releases carbon monoxide and impairs oxygenation of tissue.

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So anything that impairs oxygenation of tissue and delivery of nutrients will impair wound healing.
Q. Okay. Are you familiar with whether or not Ms. Perry smokes?
A. I don't know if she currently smokes, but there was a record of it historically.
Q. So you don't know one way or the other whether she currently smokes cigarettes?
A. As of today, no, I don't know. But during her surgery she was a smoker, and after her surgery for her mesh she was.
Q. How often did she smoke cigarettes?
A. I don't recall. It varied depending on the medical record. It didn't sound like it was a pack a day.
Q. She's a very light smoker, right?
MR. WES: Object to form.
THE WITNESS: I think -- as a physician I don't know that I'm going to answer that to a yes. I'm sorry.
MR. JONES: Q. That's fine.
A. Any smoking is bad. So yes, she was not a pack a day.
Q. Okay. And that was a relative term that I used.
A. Correct.
Q. It probably wasn't the best way to ask the question, but you understand what I'm getting at, is that

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the amount that you smoke has an impact on what we're talking about here, wound healing, correct?
MR. WES: Object to form.
THE WITNESS: It may or may not. Again, it's individual. Individual response. So what may impact one patient may not -- you know, may not impact another patient at all. So a pack a day may be a huge impact on one patient whereas another patient two or three cigarettes.
She has some history of asthma and some history of allergies, so she may actually be more impacted by her cigarette smoking than someone who doesn't have allergies or a history of episodic asthma.
So again, it's all genetic, so I can't really fairly give an answer to that.
MR. JONES: Q. Okay. You said asthma and allergies may impact. Is that going to be an opinion you're going to be offering in this case?
A. To the extent that I just did, yes.
Q. It doesn't make a difference if a person smokes two cigarettes a day versus a pack a day for wound healing?
MR. WES: Object to form.
THE WITNESS: I suspect -- yes. Yes. We're not comparing one person to another, but in an individual

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person, the more you smoke, one would assume the worst of side effects, correct.
MR. JONES: Q. So if I understand this correctly, there are patient-specific factors that would alter the wound healing process on top of diabetes, smoking, asthma, allergies, and nutrition?
MR. WES: Object to form.
THE WITNESS: Yeah, I'm not sure what -- there are other factors meaning?
MR. JONES: Q. Meaning -- here's what I'm getting at. The -- we talked earlier about Ms. Perry not being -- smoking a pack of cigarettes a day.
A. Correct.
Q. And there's reference in the medical records that she may have smoked less than a pack a day, correct?
A. Correct.
Q. And when I asked you whether the amount of cigarettes she smoked would have an impact on the wound healing, meaning the more cigarettes you smoke, it would have a greater impact on the wound healing versus the less cigarettes you smoke having a smaller impact on the wound healing, and your answer was, well, it's -- there's patient-dependent factors involved, too, correct?
A. Correct.
Q. So without knowing -- I guess what I'm getting at

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what are those patient-dependent factors that you discussed?
MR. WES: Object to form.
THE WITNESS: Yeah. So I guess I'm still not -- I don't know that we're communicating very well right now.
MR. JONES: Q. Okay.
A. I was -- one individual that has vascular insufficiency for whatever reason and smokes could have -- even if it's a couple of cigarettes, it may have a much larger impact than someone who does not have an underlying vascular insufficiency. That's all -- that's the only point I was trying to make. Nothing more than that.
Q. Okay. Are you going to be giving an opinion in this case that Ms. Perry's smoking behavior impacted her wound healing?
A. It may have.
Q. It may have?
A. Sure. Yeah.
Q. Are you reasonably certain that her smoking impacted her wound healing?
MR. WES: Object to form.
THE WITNESS: I'm reasonably certain that it may well have.
MR. JONES: Q. It may well have.
A. Yes.

Q. Will you be giving an opinion that Ms. Perry's diet affected her wound healing?
A. It may well have, yes.
Q. It may have.
Well, let's move on to C. "Inflammation occurs with any surgery - even absent mesh." That's pretty straightforward.
A. Yes, I think so.
Q. Okay. And your point there is that there's an inflammatory reaction to the mesh that's used with a TVT Abbrevo device, correct?
A. Correct.
Q. But that doesn't distinguish it from other surgeries that may treat stress urinary incontinence?
MR. WES: Object to form.
MR. JONES: Q. Flush that out -- flush that out for me.
A. So that's actually not the point.
Q. Yeah.
A. So the point is just because you have inflammation doesn't necessarily mean it's associated with the mesh. There is -- in fact, there is some inflammation associated with the mesh in the slides that -- of the mesh that was removed from Mrs. Perry, but you can have other kinds of inflammation that aren't related to the mesh, and

that was the point.
Q. Okay. There's inflammation in the medical records, but it doesn't necessarily mean it's from the mesh?
A. Correct.
Q. Okay.
A. Yes.
Q. We'll skip D and move on to E, "Chronic Inflammation." Can you flush that out for us?
A. Definitely. So the first point is, is that if it is, in fact, part of the normal healing response, you would expect it to occur. It would be abnormal if there wasn't some chronic inflammation in a healing wound.
In fact -- well, that's all -- immunosuppressed individuals, part of the problem with their wound healing is they don't have the inflammatory cells to mount that response.
And you can see chronic inflammation after surgery, but you obviously can see it without surgery for a variety of other causes. I just wanted to be sure that that was clear.
Q. Okay.
A. It is considered a normal and expected reaction to any implanted foreign material anywhere on the body.
And the other point I really wanted to emphasize,

you can see, quote, chronic inflammation, closed quote, in normal tissue, and it doesn't necessarily imply anything pathologic at all. And this is particularly true in areas of mucosa.
So in this particular example, vaginal mucosae, you would expect to see in normal vaginal mucosa a small complement of what we refer to as chronic inflammatory cells.
Q. Fair to say chronic inflammation isn't necessarily indicative of any unintended consequences of the TVT Abbrevo implant?
MR. WES: Object to form.
THE WITNESS: I think that's what I'm trying to say. I think that summarizes it, yes.
MR. JONES: Q. Okay. Would it be incorrect to say the inflammatory reaction to the mesh and the TVT Abbrevo device is minimal?
A. In this case, yes.
Q. Would it be incorrect to say the inflammatory response to the mesh used in the TVT Abbrevo device is transitory?
MR. WES: Object to form.
THE WITNESS: It's partially correct and partially incorrect. So when you put the device in -- these implants, any foreign material in, there is an

initial, quote, transitory, closed quote, inflammatory response that often includes mast cells and probably some neutrophils as well as the lymphocytes and the macrophages.
Over time that acute process dissipates and what remains is a layer, if you will, a thin layer of chronic inflammatory cells, typically lymphocytes and macrophages that sort of make a nice little layer around the foreign material, walling it off from the normal tissue.
So that does persist, but that acute sort of initial response to the body, that is transitory.
MR. JONES: Q. You mentioned walling it off. Is that, I guess, a plate, a scar plate, or is this different? Are we talking about two different things?
A. We're talking about two different things. It's not a scar plate. It's a layer of cells that's -- and there is often a very thin -- well, I won't say often. In this case because -- you know, there may be instances where you don't see what I'm describing, but in this particular case and what you'd like to see is a very thin layer -- a very thin layer of fibrosis -- fibrous tissue associated with that chronic inflammation, and that's it. Not a thick layer.
Q. Is there always a chronic inflammatory reaction when the TVT Abbrevo mesh is implanted inside the body?

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A. There should -- I would -- I expect as a pathologist anytime I see foreign material removed from the body that has been there for more than a few hours to have an inflammatory response. Absolutely. Every single time.
Q. Same for chronic foreign body response?
A. That's exactly what I'm talking about, yes.
Q. Same thing --
A. I would expect to see some kind of chronic response. It would be -- in fact, if I don't see it, it tells me that that foreign material has been very, very recently placed.
Q. Did you happen to review any of the advertising Ethicon uses for the TVT devices in this case?
MR. WES: Object to form, outside the scope.
THE WITNESS: I -- I don't specifically recall reviewing advertising, but I may have read some inserts.
MR. JONES: Q. So you don't have any recall of Ethicon in their marketing materials for the TVT devices stating there would be no chronic foreign body response to the mesh?
MR. WES: Object to form, outside the scope.
THE WITNESS: I don't --
MR. WES: Misstates --
THE WITNESS: Yeah, I don't recall reading that

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there would not be one, no.
MR. JONES: Q. Let's move on to F, "Foreign body reaction expected with the implant."
Can you flush that one out?
A. That's just, again, emphasizing basically what we just discussed, that I would expect to see some sort of reaction always to any foreign material. And in fact, sometimes normal tissue gets in the wrong spot in the body, and you would expect to see a foreign body reaction to that as well. An ingrown hair follicle, you know, if the hair shaft or keratin gets embedded in the connective tissue of the dermis will incite a foreign body reaction. And that's all self tissue, but it's in the wrong spot.
So anything that's occurring in the wrong spot should elicit some reaction.
Q. You talk about foreign body reaction remaining after an absorbable suture has been absorbed.
A. Yes. I've even seen that, yes.
Q. Okay. So if someone were to make the argument that using a partially absorbable implant in a TVT Abbrevo device would not cause a chronic foreign body response --
A. No.
Q. -- that would be incorrect?
A. That would be incorrect, yeah.
Q. There's a chronic foreign body response to an

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absorbable mesh just as there would be to a permanent polypropylene mesh?
MR. WES: Object to form.
THE WITNESS: Well, there is a -- so there is a foreign body reaction to absorbable material as well as nonabsorbable material. Whether that response lasts decades after that suture's been completely absorbed, I can't -- I really don't know that.
But in my practice I have seen where, you know, there's -- there's a persistence of that foreign body reaction. I don't see any suture anymore. Now, maybe if you do sophisticated studies, you could find little particles, I don't know, but you can see the residual sort of response even though the suture's gone.
Q. Will you be offering an opinion in this case that there is a difference in the foreign body response between an absorbable mesh and a nonabsorbable mesh?
A. No, I will not.
Q. Okay.
A. The only point is that anytime any foreign material gets introduced in the body, there will be a response.
Q. Okay.
A. And it may even last after the material's been removed.

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Q. Topic G. Have we covered that topic in some of our discussions already, or is there anything additional that you'd like to share about topic G?
A. The only other point, again, is about terminology.
Q. Okay.
A. Pathologists try to be very specific in the terms that they use, and I just wanted to emphasize that fibrosis is different from dense scarring, and that's different from fibroconnective tissue. They really mean somewhat different things.
Q. Scarring, scarification, scar plate is different than fibrosis?
MR. WES: Object to form.
THE WITNESS: Generally, yes. It really -- I mean, obviously part of that dense -- fibrosis is part of that dense scarring, but there are degrees of fibrosis quite honestly.
MR. JONES: Q. Okay.
A. And fibroconnective tissue is normal tissue.
Q. Okay. There's nothing abnormal about fibrosis occurring after a transvaginal mesh surgery?
A. There is nothing -- you would expect fibrosis after a wound. So if there's been surgery, yes. That's not abnormal. That's part of the healing process,

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correct.
Q. Topic H, "Risk of infection following surgery is well known."
A. Correct.
Q. That is what it is?
A. Yes.
Q. We don't need to flush it out?
A. Yeah, nothing else.
Q. Okay. Moving to heading Roman Numeral II, "Tissue of the Vaginal Wall." You talk about the four layers of tissue in the vaginal wall, correct?
A. Correct.
Q. Can you explain those terms and why it's important that you have included the four layers of the tissue of vaginal wall in your summary of opinions?
A. Well, I think it's important to realize that as we -- as you suggested earlier in one of your earlier questions that perhaps vaginal tissue is different from stomach tissue. This was just to emphasize that vaginal tissue is a mucosal tissue, so there's a mucosal layer that's different from skin. It's certainly different from stomach, different from hernia repairs, that kind of thing.
And then just to emphasize that there's the mucosal layer, and then beneath that what's referred to as

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submucosa, and there's a muscle layer and then the outer adventitia. There's really no adipose tissue present in the vaginal tissues.
Q. Why is that important to note?
A. Well, I think sometimes people extrapolate findings from mesh in one organ site to another organ site. Again, that was one of the questions you asked. And although in many respects, I think that it's a similar response. You would not expect it to be completely identical if you're putting it in a different kind of tissue.
So if you see adipose tissue associated with mesh material in a ventral hernia, that would be expected, but you would not expect to see adipose tissue in a vaginal tissue that contained a mesh material.
Does that make sense?
Q. Yes.
A. And that would not be -- I mean, it would be abnormal to suddenly start seeing adipose tissue.
Q. It sounds like you're saying there's a distinction between hernia repair, mesh and transvaginal mesh?
A. No. I don't know necessarily about the mesh, but the surrounding tissue.
Q. Okay.

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A. So if you see adipose tissue in the hernia repair and you don't see it in the vaginal mesh, that doesn't mean there's anything wrong. It means there's no adipose tissue there to begin with. Just to make that clear. That's all I meant.
Q. Sure. I appreciate that. We'll move on to topic III. "No gross findings because nothing but slides to review."
What do you mean by that?
A. Well, when we talk about gross findings in pathology, we're talking about the tissue that comes in through the OR. So in this case it would have been that mesh material that was removed during the mesh removal or the mucosal tissue that was removed at the tying of the mesh placement, and that I don't -- that was already done by a different pathologist. So my gross finding is really just the slides. That's all that means.
Q. You talk about the slides you reviewed.
A. Yes.
Q. What slides did you review?
A. They were recut slides from blocks that were made from the initial procedure when the mesh was placed and when the tissue -- the mesh was removed. So two different surgical procedures.
Q. Were there any conclusions or findings noted on

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those pathology records?
A. Do you mean the pathology reports?
Q. (Nods head.)
A. Yes. There were pathology diagnoses on both of them, yes.
Q. Do you recall what those diagnoses were?
A. Yes, I have them in front of me.
MR. JONES: Okay. Why don't we go ahead and mark those very quickly. We'll mark as exhibit L-2 Bakersfield Pathology Medical Group Pathology Report dated 3-25-2011.
(Whereupon, Exhibit L-2 was marked for identification.)
MR. JONES: We'll mark as Exhibit L-3 Bakersfield Memorial Hospital Pathology Report with the date of January 18th, 2012.
(Whereupon, Exhibit L-3 was marked for identification.)
MR. JONES: Q. What was the diagnosis in Exhibit L-2?
A. The pathology report diagnosis reads:
"Vaginal wall, comma, posterior, comma, excision.
"Hyperplastic squamous mucosa with patchy submucosal mild chronic inflammation and prominent vascular congestion.
"There is no evidence of viral cellular changes,

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comma, dysplasia or malignancy, period.
"All margins of excision are free of lesions and are viable."
Q. Do you have an opinion as to that diagnosis?
A. Yes, I do.
Q. What is that opinion?
A. Well, I agree that there is, in fact, squamous mucosa present and that it does, in fact, show patchy submucosal chronic inflammation. There's also some vascular congestion, which I interpret as likely procedural during the -- i.e., it was introduced during the surgical procedure.
There is some edema, and there was also some focal parakeratosis, which you often see in prolapsed squamous tissue.
Q. Okay.
A. There were also fragments of hair bearing skin from the perineum in addition to the fragments of vaginal mucosa. And, in fact, I think the predominant tissue was actually perineal tissue, it wasn't vaginal tissue.
I think we counted, I don't know, 18 or 19 fragments of tissue total, and I believe 13 of them were the perineum, and it was -- the minor component was actually squamous mucosal tissue.
Q. What does that indicate to you as a pathologist?

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A. It indicates there was a significant amount of that perineal tissue that was removed during that procedure.
Q. Do you disagree with the diagnosis in this pathology report?
A. I agree with the diagnosis. I just think it's incomplete because they didn't note that there was a fair amount of skin there as well, but other than that, there's no substantive disagreement at all.
Q. Okay. And if someone sitting on the jury asks for the most plain English way to communicate the findings of this pathology report, what would your testimony be?
A. That there was -- let's stop. Ask the question again.
Q. Here's what I'm getting at. These are some complicated concepts, terms that people aren't commonly familiar with, right?
A. Correct.
Q. Very specific to the pathology field?
A. Correct.
Q. So if someone's sitting in the juror box and a juror says, "I don't understand anything that you just said," could you break it down in language that someone who is not a pathologist could understand? That's what I'm getting at.

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MR. WES: Object to form.
THE WITNESS: Yes, I can try to do that. So looking at the slides, there were -- first of all, all the tissue that was submitted to the pathologist was actually submitted for a histological examination. Sometimes we just do representative submission, but all of it -- all was submitted. I just wanted to be sure that I was correct.
Of that tissue -- of those tissue fragments, I actually have the numbers here now I noticed. Eight were from the vagina, and those vaginal fragments show changes that are consistent with prolapse, which is bulging of the vagina usually distally, which is part of the reason why -- indirectly part of the reason she was having urinary incontinence.
In addition, there were multiple fragments of skin that was removed along the region of the opening of the vagina. And in fact, there were more fragments of that than the vaginal tissue. There were 13 fragments of those.
MR. JONES: Q. And other than your comment about it being incomplete, you don't have any substantive disagreements?
A. That's correct.
Q. Okay. Let's move on to Exhibit L-3, which is the

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path report related to the explant surgery, right?
A. Correct.
Q. What were the find -- final diagnosis in this pathology report related to the explant surgery?
A. "One irregularly shaped portion of mesh-like material with surrounding portions of fibroconnective and focally non-keratinized squamous epithelial, back slash, mucosal tissue with mild chronic inflammation, back slash, fibrosis with no dysplasia or malignancy identified."
Q. Do you have any substantive disagreement with that diagnosis?
A. No, I don't. I would add, if that's all right, that the specimen -- the tissue's really fragmented and the mesh material is really fragmented from the processing. And so it's -- this particular pathologist didn't make a lot of comments about the mesh, and that's largely because it's -- it's a distorted specimen from processing.
Q. What processing are you speaking about?
A. The -- I think the removal and then the sectioning, the tissue sectioning. I think the way it was embedded and then the knife cut. It likely -- a combination of those factors. There is -- in addition, there was an area of mucosal disruption if -- I think that's the best term to use.

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And in association with that area of mucosal disruption, there was more inflammation than was evidenced around that actual mesh material. And there was some organizing fibrosis, which I interpret as a non-healing wound. And this was associated, of course, with the mucosal aspect, not the underlying mesh material, which was in the submucosal tissue.

Q. Okay. So there's some healing issues involved here?

A. Yes. In this mucosal wound, yes.

Q. Okay. And you talked earlier about smoking and diet and diabetes being related to healing, correct?

A. Correct.

Q. Will you be offering an opinion in this case that there was impaired wound healing from Ms. Perry and the cause of that impaired wound healing was her diet and her smoking behavior?

MR. WES: Object to form.

THE WITNESS: My opinion is that there is a non-healing wound, and it appears chronic. And there are a variety of factors that may contribute to non-healing wounds, and some of these factors are smoking, you know, diabetes. I mean, alcohol intake, I don't know that she's a big drinker, but I mean there's a whole lot of factors that could play into non healing, impaired vascular

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supply, et cetera.

MR. JONES: Q. Okay. Have we covered all of the aspects of both pathology reports related to the opinions that you intend to offer in this case?

A. Well, there's a -- essentially we have, yes. Other than this non-healing wound and the thin layer of lymphocytes and macrophages around the mesh material, which you would expect to see, there really were very few giant cells.

There really wasn't a significant multinucleated sort of -- multinucleated giant cell reaction, foreign body giant cell reaction. There's nothing concerning about the response of the tissue to the mesh material.

Q. Okay.

A. There is normal vascularization of the tissue. There's no significant acute inflammation, and by that I imply there's no evidence of infection because infection would be one reason to have a non-healing wound, of course.

There were also no large nerve fibers. I received several unstained slides. And I did an S-100 stain on one of the unstained slides, and there were small little nerve twigs, none of which were abnormal in configuration. They were in the appropriate distribution of the submucosal tissue.

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There was no evidence of a traumatic neuroma. There was certainly no large nerve fiber.

Q. What does that mean?

A. So part of the reason she was having the mesh removal is pain. Certainly part of it was the husband, but she also had some pain. And although we often don't see an obvious cause of pain when we examine histologic tissue removed from patients with pain, sometimes we do see the cause of it, and one of them would be a large nerve sitting right next to a foreign body. You would assume -- or you would presume that that was probably impinging on that nerve.

Q. Okay. Impinging or entrapped or --

A. Or just anything. Just pushing on it will cause pain, but there were no large nerves there.

Q. Okay.

A. And then the only other thing is there was no real necrosis. Again, necrotic tissue will not heal, but I didn't see any necrosis.

Q. Okay. You said that one of the reasons why Ms. Perry had the mesh removed was because of pain, correct?

A. Correct.

Q. And you said often you won't see factors that would indicate pain in the histology, correct?

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MR. WES: Object to form.

THE WITNESS: I think what I was trying to convey is that -- let's see. Clinical and histologic correlation or clinical pathologic correlation is not always perfect in cases of pain, first of all. We may not see any good cause of pain, and the patient has pain.

We may also see what we interpret as a cause of pain, i.e., a large nerve, and maybe the patient never had pain. You call up and you say, well, oh, that's interesting, the patient never complained about it.

So that correlation is not perfect. That doesn't mean we still don't try. That's the only point I was making

MR. JONES: Q. Sure. What does cause pain?

MR. WES: Object to form.

THE WITNESS: That's a very complicated question.

MR. JONES: Q. Do we know what causes pain?

MR. WES: Object to form.

THE WITNESS: Well, at some level we know that there are sensory nerves that if they are injured or sense obnoxious stimuli, we perceive pain. That's a simple way of talking about it, and I don't know that we want to go in much more depth.

MR. JONES: Q. No.

A. And that's really not in my area of what I want

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to be doing with my opinion.
Q. Okay.
A. If that's okay with you.
Q. It is okay. Here Ms. Perry is complaining of pain, correct?
A. Correct.
Q. And is there anything in the pathology records that would indicate what the cause of her pain is?
A. Okay. So I'm not so certain about the actual pathology reports, but I do think the abundant material of that perineal, the skin around the vaginal introitus, suggests that perhaps the result -- resulted in too much narrowing of that opening, vaginal opening, and that will certainly cause pain.
Q. Will you be giving an opinion in this case that Ms. Perry's pain is caused by vaginal narrowing?
A. I think to a certain extent it is, yes.
Q. Is the mesh causing Ms. Perry any pain?
A. I see no histologic evidence for that, no.
Q. It doesn't mean that the mesh isn't causing her pain, it just means you don't see anything in the histology that would --
MR. WES: Object to form.
MR. JONES: Q. -- be indicative of mesh causing the pain?

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A. I think that's -- I think it's okay to say that, yes.
Q. Okay.
A. There's nothing on the basis of what I see that I would expect that that -- or attribute any of that pain to the mesh.
Q. And as we discussed before, there's not a perfect correlation there between what you see in the histological records and how it relates to pain?
MR. WES: Object to form.
THE WITNESS: I think that's correct, yes.
MR. JONES: Q. Sometimes you look at the pathology and there's something there and you say, yep, this is causing the pain, correct?
A. Oh, I see what you're asking. Yeah, on occasion we do. I guess the point I was trying to make about the mesh not -- there's no evidence for the mesh being the etiologic -- the cause, if you will, of her pain is that number one, I don't see anything in the slides. That's the first observation.
And the second observation is that based on all my experience looking at lots and lots of foreign material, this looks -- the response, the normal tissue response, to this mesh material looks similar if not -- or if anything much milder than I have seen with other

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foreign material that has not been associated with pain at all.
So I would not expect that to be associated with pain, either. Not only do I not see anything, I would not expect pain to be associated with this mesh --
Q. Okay.
A. -- based on all my experience and in this particular case as well.
Q. What experience are you referencing?
A. Looking at all kinds of foreign materials that have been removed from all different organs.
Q. What foreign materials?
A. Mesh as well as all kinds of medical devices.
Q. What type of mesh?
A. Some of them would be propylene. I don't know all the meshes.
Q. So you've --
A. Any foreign material basically.
Q. So you've examined explanted polypropylene mesh from the vagina before?
A. Yes.
Q. And you've seen -- what have you seen when you've examined explanted transvaginal mesh?
A. Often findings very similar to this. In some cases I've seen more inflammation. A couple of cases have

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been removed for actually acute infection, and so you see it more in the way of acute inflammatory cells.
Q. How many times have you examined explanted transvaginal mesh?
A. I would -- I'm estimating. I would say grossly it would -- minimal would be probably a couple dozen and then microscopically half a dozen. We don't do microscopic examinations on all explanted mesh material.
Q. When did -- these 24 times, roughly, that you've examined explanted transvaginal mesh, when did that occur? What time frame?
A. Oh, in the last -- as far as I can remember, I don't really know.
Q. Last 20 years?
A. I've been practicing -- well, maybe not 20. Last ten.
Q. Okay.
A. I mean, I don't remember that far. But it's just in my regular practice, not any kind of -- not in the context of a legal case by any --
Q. That was going to be my next question. So in the course of your normal pathology practice, you've examined roughly two dozen explanted transvaginal mesh?
A. I would say minimum.
Q. Minimum.

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A. Yes.
Q. But --
A. Likely more.
Q. Likely more?
A. But minimum, yes.
Q. Can you give a range?
A. Oh, no.
Q. Ceiling floor?
A. Oh, I don't think more than -- I would say probably not more than three dozen.
Q. Okay.
A. But I mean, I could be wrong.
Q. When you've examined these explanted transvaginal mesh implants, why were you doing that?
A. Because they were submitted to pathology.
Q. Okay. Do you know why the mesh was removed?
A. Sometimes we do, and sometimes we don't.
Q. Okay. It's fair to say women don't have mesh removed unless there's some sort of complication that presents itself that makes it appropriate to remove that mesh, correct?
MR. WES: Object to form, assumes facts not in evidence.
THE WITNESS: It -- typically you would expect that, but I don't know that that was always the case in

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some of the cases that I reviewed.
MR. JONES: Q. But it's fair to say women have mesh removed because of complications, right?
MR. WES: Same objection.
THE WITNESS: I -- I'm not sure I feel comfortable saying yes to that because, as I say, there was a fair number that we get the mesh in, and there's no clinical history. So I don't -- when I get a clinical history of a complication, yes, absolutely, that's why they're removing it.
MR. JONES: Q. Okay.
A. Otherwise, I don't necessarily know why.
Q. When Ethicon sells the TVT Abbrevo mesh, it doesn't intend for that mesh to be removed, correct?
MR. WES: Object to form, outside the scope of her opinions.
THE WITNESS: It really is outside my scope.
MR. JONES: Q. You don't know one way or the other whether --
A. It's not --
Q. -- mesh is removed?
A. -- implanted as a temporary. My understanding it is not considered -- you know, this is -- you know, like birth control implants they take out after three years. That's not what the intended life span of these mesh is.

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That I can say, yes.
Q. Let me ask a better question. When Ethicon sells the TVT Abbrevo mesh, it's intended to be a permanent implant?
A. I believe so, yes.
MR. WES: Same objection.
MR. JONES: Q. Let's get back to your opinion summary. And we already talked about your overall conclusions related to the pathology reports, correct?
A. Yes, I think so.
Q. We've covered that. Are there any additional opinions related to the pathology slides that you reviewed beyond the pathology report?
A. I don't think so. I'm not sure I'm understanding your question.
Q. Yeah, let me ask a better question. What opinions will you be giving related to the pathology slides in this case?
A. My opinion is that there is mesh material present, that it is lined by a very thin layer of lymphocytes and macrophages with associated fibrous tissue, which is normal and expected.
There is no other abnormality or concerning finding associated with the mesh itself. However, there is a mucosal non-healing wound that is not attributed to

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the device itself but I think is likely a complication from the surgery on the prior incision.
Q. In jumping ahead to page 3, number III, "Overall, chronic inflammation is mild with focal area of more moderate inflammation at the site..."
What do you mean by that?
A. Again, there's a very minimal chronic inflammation in the submucosal tissue, and it's comparable in amount to the presence of the chronic inflammation that was present in her vaginal tissue at the time of the mesh insertion.
However, at that area of the mucosal disruption, there's more significant, more moderate -- it's a more striking and chronic inflammatory process, which is in keeping with this chronic non-healing wound.
Q. Let's move to 14. "No evidence of shrinkage of the mesh in vivo."
What do you mean by that?
A. I was asked was there evidence of shrinking, and first of all, I mean, I don't know how you'd know that other than obviously a huge retraction, which there's not. But there's no dense scarring or fibrosis that would lead you to think that it's been compressed.
And then I just wanted to emphasize that if people were going to try and extrapolate the measurements

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of the tissue that was removed and make a comparison to what normal mesh should be measuring, that that's a bit inaccurate would be the polite way to say that.

As soon as you remove anything from the body, it retracts. Any kind of tissue retracts. And then once it's in formalin, it retracts even more. Formalin fixate -- fixation. And measurements in a gross are rough. They're using quick millimeters. They're not doing exact measurements. So that's the only point I wanted to make. Surgeons are well aware of that.

Q. Have you reviewed any testing by Ethicon related to shrinking mesh?

A. No.

Q. Okay.

A. Not that I recall.

Q. So you don't know one way or the other if the testing that you just described is inaccurate, whether Ethicon's run that actual testing or not?

MR. WES: Object to form, outside the scope.

MR. JONES: Q. Meaning the gross measurements of look at the size pre-implant, look at the size post-implant, there's a difference, ah-ha, there must be shrinkage? That's what you were referring to as inadequate or inaccurate, right?

A. Correct.

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MR. WES: Same objection.

THE WITNESS: Yes. I'm not sure about -- no, I don't know that an Ethicon study has done that.

MR. JONES: Q. Okay.

A. That I'm aware of, no.

Q. Are you aware of any testimony from Ethicon doctors, medical directors or engineers or internal Ethicon documents that state the mesh used in the TVT shrinks up to 50 percent?

MR. WES: Object to form, outside the scope.

THE WITNESS: It really is not part of my opinion.

MR. JONES: Q. So that doesn't matter to you either way whether Ethicon itself says mesh shrinks?

MR. WES: Same objections. Also, argumentative.

MR. JONES: Q. Let me restate the question. Does it matter to you in forming your opinions in this case that Ethicon employees, including medical directors and engineers, have stated that the mesh used in the TVT Abbrevo device shrinks up to 50 percent?

MR. WES: Same objections.

THE WITNESS: In the formation of my opinion, looking at the slides, it has no relevance, yes. Those things may all be true, but that's not part of my opinion and --

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MR. JONES: Q. Will you be giving an opinion in this case that the mesh does not shrink?

A. No.

MR. WES: Object to form.

MR. JONES: Q. Okay. Your opinion is I've looked at the pathology records, I don't see anything indicative of mesh shrinkage?

A. Yes. If you mean the slides and the pathology in the pathology reports, absolutely, yes.

Q. Okay. Have you reviewed any medical literature related to shrinkage of mesh in vivo?

A. Yes, I believe I have.

Q. What literature would that be?

A. I don't recall it off the top of my head, but I'm sure it's on that device that they -- the USB device that would involve all the materials they provided me.

Q. So we can take that thumb drive that you and counsel have provided, look at the medical literature there and find articles related to mesh shrinkage that you have read and reviewed?

A. That I have reviewed.

Q. Okay.

A. There's levels of review, yes.

Q. Okay. What levels of review?

A. Well, again, this is not exactly in my area of

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expertise -- or at least it's not in the area of where I'm forming my opinions. So I didn't focus my attention chiefly on that. I focused my attention on the pathology.

Q. Okay. And then the final entry on the summary of opinion under number 16. Can you explain what you mean there?

A. Certainly I think I may have mentioned this already. Number 16 basically reads: Other than a non-healing wound, which is present in the region of the vaginal mucosa and not attributable to the device or to the mesh itself, there is really no significant tissue reaction to that mesh other than the thin layer of lymphocytes and macrophages that's expected. There's no dense fibrosis.

All those things that I said were not there are not there, and I think that that wound is likely a complication from the surgical procedure. The incision may have healed initially but must have broke down. 'Cause it really does look like it's a chronic non-healing wound to me.

Q. Any additional opinions you intend to offer in this case that we haven't discussed and are not included on this summary of opinion sheet?

A. No.

Q. We've covered it all?

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A. I believe we have.
Q. Okay.
A. Either we have in this deposition or it's on this sheet, yes.
Q. Okay. And -- excuse me. Just in an attempt to try to break it down, there's some healing issues involved in this case, correct, in your opinion?
A. Yes.
Q. Impaired healing, correct?
A. Correct.
Q. And it's your opinion the mesh is not the cause of Ms. Perry's pain, correct?
MR. WES: Object to form. It assumes facts.
THE WITNESS: It's my opinion that it's highly unlikely that the mesh is what's causing her pain. I think that's true based on what I've seen and reviewed. I think it's for more likely attributed to the colporrhaphy procedure.
MR. JONES: Q. Why do you say that?
A. For the reasons that I mentioned earlier. In other words, the removal of all that skin tissue around the vaginal opening causing that opening to be narrower and tighter.
Q. Okay. Let's move on to what you're relying on for the opinions that you've discussed.

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Counsel, did you bring with you some materials today that include her reliance materials --
MR. WES: Yes.
MR. JONES: -- that we can mark for the record?
MR. WES: They are on this flash drive.
MR. JONES: Okay. I'm going to go ahead and mark this flash drive as L-4. I'll take it with me, but we'll mark it for the record as Exhibit L-4.
(Whereupon, Exhibit L-4 was marked for identification.)
MR. JONES: Q. On this thumb drive -- first off, Doctor, did you create this thumb drive?
A. No.
Q. Counsel created this for you?
A. Yes.
Q. Have you looked at what's on this thumb drive?
A. No.
Q. Okay. You've relied on counsel to adequately put all your reliance materials on this thumb drive?
A. Yes.
Q. Okay. So if there's a mistake, it's their fault, right?
A. Their mis --
Q. That's tough.
A. -- take -- their mistake.

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Q. Did you review every single item on this thumb drive? First off -- let me backtrack.
Do you know what's on this thumb drive?
A. My understanding is it's everything that's been sent to me.
Q. Did you review everything that was sent to you?
A. No, I have not reviewed everything. There's been a number of things that have been sent in the last few days that I've not reviewed.
Q. What's been sent in the last few days?
A. I'm not even sure what they are. There was something that came last night. I have not opened it so...
Q. Okay.
A. Some of it may be depositions --
Q. Hot off the press deposition --
A. -- that I'm really not aware.
Q. -- transcripts perhaps.
A. Well, no, it's not always that. There's something --
Q. Go ahead.
A. -- the other day that wasn't --
THE REPORTER: Okay. I couldn't get you both talking at the same time.
Go ahead.

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MR. JONES: Q. How can I make a determination of what on this thumb drive you reviewed and what you haven't reviewed?
A. I don't know.
Q. Okay. I mean, you understand --
A. I know.
Q. -- I've got to know what you're relying on, what you reviewed, right?
A. Well, to a certain extent, yes. But most of my opinions that I've expressed particularly about this case are really based on pathology, my review of the slides. I'm really not opining on many of those things that were submitted to me.
Yes, I'm relying on Ms. Perry's medical record and all those issues that have been associated with her initiating her mesh placement at the beginning and then the subsequent removal of that and some of that follow-up. Those things certainly I'm using.
Q. That's an easy one.
A. Right.
Q. Pathology slides --
A. Exactly.
Q. -- the pathology reports?
A. And the medical records.
Q. The medical records --

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A. Of course, yes.
Q. -- Ms. Perry's deposition and Mr. Perry's deposition?
A. Yes.
Q. Earlier I asked you did you review medical literature related to mesh shrinkage, and you answered yes, right?
A. I think I have, yes.
Q. And then I asked you what literature that was, and you couldn't recall.
A. Correct.
Q. And then I said I'll be able to go to this thumb drive and look at the literature related to mesh shrinkage that you reviewed?
A. Correct.
Q. But you didn't review everything on this thumb drive, right?
MR. WES: And Counsel, I can just stipulate that we'll let you know what materials were added that I guess she just got in the last couple of days that you haven't got a chance to review. And we can narrow down for you anything that -- that she hasn't reviewed as of today's date in preparation of her opinions.
MR. JONES: I'm not so much worried about what's been submitted to her the last couple of days. I more

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want to get the universe of what she reviewed --
MR. WES: Sure.
MR. JONES: -- versus, you know, all the stuff that you sent out to her.
MR. WES: Yes.
MR. JONES: Can you endeavor to produce a list or a thumb drive with materials that she actually looked at so I can know what she's relying on for her opinions?
MR. WES: Yeah. We can narrow down -- you know, if there's anything that goes --
MR. SNOWDEN: Those are two different questions.
MR. JONES: Yeah, you can answer them both if you want.
MR. WES: Right. And so we'll -- I mean, we will give you the entire universe of what she's reviewed and what are -- how are the questions -- what's your second question?
MR. JONES: It's almost an either/or question.
MR. WES: Okay.
MR. JONES: I either need a list of what she actually did look at --
MR. WES: Right.
MR. JONES: -- or a thumb drive of what she actually looked at.
MR. WES: Right. And so everything that she

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looked at is on this drive. We just need to tell you basically what --
MR. JONES: Yeah.
MR. WES: -- is on this drive that -- that she --
MR. JONES: There's the road.
MR. WES: -- didn't necessarily look at.
MR. JONES: There's the road. At the moment I have no way --
MR. WES: So we will narrow that down for you. Whether it makes more sense to produce another one of these -- probably it makes more sense for us to just tell you, you know, here's the items on the drive.
MR. JONES: Okay. And you'll endeavor to do that?
MR. WES: We will do that.
MR. JONES: Okay. I appreciate that.
Q. So it sounds like once we get a list of materials that are on this thumb drive that you actually reviewed then we can look at that list and decipher here's medical literature that you actually reviewed, correct?
A. Yes.
Q. Okay. But at the moment everything on this thumb drive you didn't review?
A. I don't know that I have.
Q. Okay.

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A. I may have. I don't know.
Q. There's just no way to tell?
A. I just know that they've sent things that I have not reviewed, and I assume they're on that drive.
Q. Okay. We touched on this earlier, but I need to go back to it.
Internal Ethicon documents, did you review any?
A. I may have, and if I did, they will be on that disc.
Q. Okay. But at the moment there may be Ethicon documents on this thumb drive that you didn't review?
A. I don't think so. I just don't recall.
Q. Okay.
A. I don't think so.
Q. Okay.
A. If I have them. If I -- I think I've seen some. Again, I'm not sure what -- I don't want to sound ignorant, but I'm not really sure what you're asking me when you say "internal documents," quite honestly.
Q. Testing that Ethicon ran.
A. I think I've seen some of that, yes.
Q. You think you have?
A. I think so, yeah.
Q. Okay. Ethicon e-mails?
A. No. I've not seen any e-mails that I'm aware of.

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Q. Have not reviewed a single e-mail?
A. I don't think so, no.
Q. Do you have any recall of what type of testing documents from Ethicon you reviewed?
A. Not at this point. No, not at this time.
Q. Okay. And no recall of the specific medical literature that you reviewed?
A. Not specific. I read a lot of long-term follow-up studies of mesh material. I've reviewed medical literature related to colporrhapy procedures, medical literature concerning indications for performing these surgeries, some of the urologic society's statements about recommendations for these procedures. Those are the kinds of things that I reviewed.
Q. Okay. Do you recall reviewing any literature that would be contrary to the opinions you're giving in this case?
MR. WES: Object to form.
THE WITNESS: No, I don't know of any literature that would be -- that would be contrary to what I'm -- to my pathology findings. None, no.
MR. JONES: Q. What about to your any findings beyond your pathology findings?
MR. WES: Object to form.
THE WITNESS: Yeah, I don't know what you're

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asking.
MR. JONES: Q. Well --
A. I'm sure there's something you're asking me, but I don't know what it is.
Q. You limited it to your pathology findings, which makes me wonder are there other findings that you're speaking about?
A. Oh, no. No, I think that -- well, I mean, let's just cut to the chase. You are talking about some studies that have shown shrinkage of the mesh, and I see no evidence of shrinkage. So in vivo I don't see -- once it's in the body, the issue of shrinkage appears to me based on my readings and what I've seen on the slides a moot issue. Not significant.
There may well be, and I have seen at least some of these studies that talk about shrinkage. Whether that has any relevance clinically in this case and in this particular patient or in general at this site, I'm not -- I don't necessarily see that it transfers over. So that is my opinion.
Q. Okay.
A. But that's it.
Q. So you have reviewed literature that concludes that the mesh shrinks?
MR. WES: Object to form.

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THE WITNESS: I've reviewed literature addressing shrinkage of mesh ex vivo, invitro, not in the body. I don't know that I've read about any shrinkage in the body. That's why I brought it back to pathology.
Q. Okay.
A. But other than that I don't remember or recall any specific literature, but I know that there's discussion about --
Q. Are you familiar with any pathology articles by Vladimir Iakolov (phonetic)?
A. How do you spell that?
Q. I don't know. Does it ring a bell, though, at all?
A. I don't -- well, I don't know. I don't think so.
Q. Okay.
A. But I might. If you spelled it, maybe I would know who it was. Is it with a Y?
Q. It's with an I. I'll take a guess and say it's I-A-K-O-L --
A. I don't know.
Q. -- O-V.
A. It's possible. It will be on there.
Q. Did you review plaintiff's independent medical examination?
A. Who was that?

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Q. I think Dr. Margolis.
A. I reviewed his -- not his deposition, no. I read parts of it, but I don't think I've received that yet.
Q. Okay.
A. Or maybe that's what I received. I've not read it. If I have received it, I have not read it
MR. WES: And listen carefully to what he asked. He asked if you reviewed her -- his independent medical examination, not his deposition specifically.
THE WITNESS: Oh. What's his independent medical examination? Oh. Oh, I don't know that I've -- I may have. He took some photographs. I did see those.
MR. JONES: Q. Okay.
A. Yes.
Q. Okay. So it sounds like you have reviewed plaintiff's independent medical examination --
A. I may have.
Q. -- by Dr. Margolis?
A. I may have. I've seen the pictures anyway.
Q. And you reviewed statements from professional societies like AUGS?
A. Is this A-U-G-S that you're talking about? Yes.
Q. Yes.
Counsel provided those statements to you?
A. Yes.

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Q. Did you do an independent literature search?
A. No.
Q. All the literature counsel provided to you that you've reviewed?
A. What is the question?
Q. Did you review any literature beyond what counsel provided to you?
A. No.
Q. So it's fair to say all of the literature that you've reviewed in forming your opinions in this case has been provided by Ethicon's counsel?
MR. WES: Objection to form, misstates.
THE WITNESS: Well, my opinion's also based on sort of, you know, my general pathology and GYN pathology background and training as well, but I didn't go out and actively look for an article on transvaginal mesh.
MR. JONES: Q. Okay.
A. I may have requested articles from Mr. Snowden.
Q. Do you have any recall of what those articles were?
A. No. It would have been general -- not a specific article, but just general topics, but no, I have not pulled -- there's not anything that I've reviewed that's not on that disc.
Q. Okay. Will you be testifying about any TVT

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products other than Abbrevo?
MR. WES: Object to form, outside the scope.
THE WITNESS: I'm not sure I'm really necessarily testifying about Abbrevo except in this particular example.
MR. JONES: Okay.
MR. WES: Are we doing okay? We've gone about an hour and a half. Do you want to take a break?
THE WITNESS: Well, if not now, soon.
MR. JONES: Let's take a break.
(Short break taken.)
MR. JONES: All right. We're back on the record from a quick break.
I want to mark for the record Exhibit L-5, which is the deposition notice, Exhibit L-6, which are the response and objections filed to the deposition notice.
(Whereupon, Exhibits L-5 and L-6 were marked for identification.)
MR. JONES: Q. If you look real quickly at Exhibit L-6, on the top left there's some law firms mentioned. Do you recognize the law firm of Tucker Ellis, Doctor?
A. Yes.
Q. Have you worked for Tucker Ellis in the past?
A. Not that I'm aware of.

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Q. Okay. Are you familiar with the law firm Butler Snow?
A. Yes.
Q. Okay. Have you worked with the law firm Butler Snow in the past beyond this particular case?
A. I don't believe so, no.
Q. Do you know William Gage?
A. No.
Q. Do you know Burt Snell?
A. S-N-E-L-L. I'm aware of the name. I don't know if I have, actually.
Q. Okay.
A. I don't think I've met him, but whether I've talked to him or not, I don't know.
Q. And then the third law firm listed Bowman and Brooke, LLP. Are you familiar with that law firm?
A. Actually, I don't think I am.
Q. Okay. So you haven't worked for them in the past?
A. No.
MR. JONES: Okay. I'll put those away. We'll mark as Exhibit L-7 an invoice related to this case.
Go ahead and hand this to you.
(Whereupon, Exhibit L-7 was marked for identification.)

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MR. JONES: Q. What does Exhibit L-7 represent?
A. It's an invoice that my administrative assistant submitted to -- I'm not really sure where she submitted it, but she -- I think -- Johnson & Johnson ultimately, I think, foot the bill -- the invoice went to, but it says Butler/Snowden and Ethicon Gynecare Pelvic Mesh, but I think it actually ended up going to Johnson & Johnson.
Q. And is that what you've billed for your time in this case so far?
A. Yes, it is.
Q. And is that the totality of your time thus far that you've spent on this case?
A. No.
Q. No?
A. This is what I've billed.
Q. This is what you've billed?
A. Yes.
Q. Can you estimate beyond what's represented in Exhibit L-7 how many hours you've spent on this case?
A. Yes, I can estimate.
Q. And what is that estimate?
A. Would you like that?
Q. Yes, please.
A. I think I would estimate about 24 hours in discussions with attorneys and then maybe another 50,

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60 hours review of literature.
Q. You say 50 to 60?
A. That's an estimate. I could be off a little bit. My AA is keeping recent hours, but she didn't keep the early hours. And so I'm having to go find my notes on those, and I haven't found them yet.
Q. And what are you charging per hour?
A. $500 an hour.
Q. So 24 hours with attorneys, an estimate?
A. Yes.
Q. Fifty to 60 hours looking at medical literature, correct?
A. Correct, minimum. Perhaps a little bit more, correct.
Q. How about review of medical records?
A. That's included.
Q. Okay. So 80ish -- around 80 hours thus far you've spent working on this case?
A. Yes, minimum.
Q. A minimum of 80 hours so far you've spent working on this case?
A. Yes.
Q. At $500 an hour?
A. Correct.
Q. So we can take your per hour fee, times it times

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the estimated hours you've spent on this case and get an estimate of the total fees you will collect in this case?
A. Well, that I will bill for them.
Q. Okay.
A. Yes.
Q. Will you be charging $500 an hour for your deposition testimony?
A. Yes.
Q. Do you have a different fee for trial testimony?
A. I believe I do, and I do not recall that right now.
Q. Okay.
A. My AA has that.
Q. That's something you'd be willing to provide, though?
A. Absolutely, yes. And I really should have brought it, but I forgot. I knew you would ask that.
Q. Sometime prior to trial --
A. Definitely.
Q. -- we'll get a copy of that, though.
Is it more or less than $500 an hour?
A. Well, I think it includes travel time. I really don't recall.
Q. You don't have any recall of whether it's more or less than your $500 an hour fee?

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A. It might be by day. I just don't -- I honestly do not remember.
Q. Okay. That's common. In addition to the $500 an hour that you charge to work on this case, you're also reimbursed for travel and other costs associated with this case?
A. Only for testimony.
Q. Okay.
A. There's no other -- yeah, only for testimony.
Q. So $500 an hour to review records and medical literature, correct?
A. Yes.
Q. $500 an hour to meet with attorneys and discuss the case?
A. Yes.
Q. And then a separate fee for trial testimony, correct?
A. Yes.
Q. And then reimbursement of travel expenses, for example, to trial and if you are called to testify?
A. Correct.
Q. Okay. Does that represent the total universe of the fees that you'll be charging in this case?
A. Yes.
Q. Doctor, do you have a field of specialty inside

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of the field of pathology?
A. Yes.
Q. What is that area of specialty?
A. Broadly speaking it's surgical pathology, but within the realm of surgical pathology, I'm a gynecologic pathology and GI pathology subspecialist.
Q. Do you have a major emphasis in a particular area related to cancer?
A. Most of my research is centered around GYN or GI cancer, yes.
Q. Okay. Do you hold yourself out on a Stanford website to have a major emphasis in ovarian cancer and ovarian tumors?
A. Yes.
Q. Okay. Most of your research -- in fact, close to all of your research is related to cancer, correct?
MR. WES: Object to form.
THE WITNESS: Not all -- not all of it.
MR. JONES: Q. The majority of your research is related to cancer, correct?
MR. WES: Same objection.
THE WITNESS: A substantial amount of my research is related to cancer.
MR. JONES: Q. Have you ever published an article relating to polypropylene?

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A. No.
Q. Have you ever published an article related to stress urinary incontinence?
A. No.
Q. Have you ever published an article related to pelvic mesh?
A. No.
Q. So your area of specialty is not pelvic mesh, correct?
MR. WES: Object to form.
THE WITNESS: That's correct. I am not a pelvic mesh product expert --
MR. JONES: Q. Okay.
A. -- or focused on that in research.
Q. Have you published any articles on mesh complications?
A. No.
Q. Have you taught any courses related to polypropylene?
A. No.
Q. Made any presentations related to polypropylene?
A. No.
Q. Taught any courses related to pelvic mesh?
A. No.
Q. Made any presentations related to pelvic mesh?

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A. No.
Q. Have you reviewed any material safety data sheets in this case?
A. What are -- I may have. I'm not sure what a material safety data sheet is.
Q. Okay.
MR. JONES: I'm going to mark as Exhibit L-8 a copy of your CV, which I will give you.
(Whereupon, Exhibit L-8 was marked for identification.)
MR. JONES: Q. I just have a few questions about your CV. Under professional memberships, page 2, you've been a member of the International Society of Gynecological Pathologists since 1996, correct?
A. Correct.
Q. Since you've been a member of that organization since 1996, has there ever been a discussion of polypropylene mesh used in mid -- I'll rephrase the question.
Since you've been a member of the International Society of Gynecological Pathologists, has there ever been a discussion of complications resulting from transvaginal mesh?
MR. WES: Object to form, overbroad.
THE WITNESS: When you ask this question, are you

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asking me was there a formal seminar or meeting to discuss these?
MR. JONES: Q. I'll break it down. First I'll ask you related to formal seminars or meetings.
A. No.
Q. Informal discussions?
A. None that I'm aware of.
Q. Okay. So since 1996 as a member of the International Society of Gynecological Pathologists, you have no recall whether in formal meetings or informal conversations of complications resulting from transvaginal mesh?
MR. WES: Object to form.
THE WITNESS: That's correct.
MR. JONES: Q. Would that hold true for these other societies that you're a member of?
MR. WES: Object to form.
THE WITNESS: Again, there's no -- I'm not aware of any discussions. I don't go to all these meetings. There may have been one that occurred, but nothing that I'm aware of or attended or even recall being posted that one would be -- there would be one.
MR. JONES: Q. If you turn to page 4 under "Editorial Board," you've listed several journals that you serve on the Editorial Board for; is that correct?

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A. Yes.
Q. Since 1996 you've served on the Editorial Board of the International Journal of Gynecological Pathology?
A. Yes.
Q. Do you have any recall of ever seeing a single article related to mesh complications in your role as an editor on the International Journal of Gynecological Pathology?
MR. WES: Object to form.
THE WITNESS: No, I've never reviewed an article on that.
MR. JONES: Q. Have you ever reviewed an article on mesh complications?
A. For publication?
Q. (Nods head.)
A. No.
Q. In your role as an editor on these journals, have you ever reviewed an article related to polypropylene?
A. No, or at least not that I remember.
Q. Okay. Then you have Journal Ad Hoc Reviewers, and you have listed the American Journal of Obstetrics and Gynecology, correct?
A. Correct.
Q. And so you've reviewed articles that are being submitted for publications in that journal?

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A. Correct.
Q. Have you ever reviewed any articles related to polypropylene?
A. Not that I'm aware of.
Q. Have you ever reviewed any articles related to transvaginal mesh?
A. Not that I'm aware of, no.
Q. Have you ever reviewed any articles related to mesh complications?
A. No.
Q. If you go to page 8. You've listed courses that you've taught, correct?
A. Correct.
Q. And at the very bottom there's a course with the date 2013 called "Human Health and Disease," correct?
A. Correct.
Q. And that's within the gynecologic pathology field, correct?
A. Yes. I'm not seeing where you're referring to, but yes.
Q. Okay. Page 8.
MR. WES: Is this the version of the CV that we just gave you, or is this a different version?
MR. JONES: Could be a different version.
THE WITNESS: Must be.

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MR. WES: Because I think what we gave you was the most up-to-date CV.
MR. JONES: Q. Okay. Well, do you see on the CV you have a copy of where you've listed courses that you've taught?
A. Yes.
Q. And you've listed a course for 2013 called "Human Health and Disease," correct?
A. Yes.
Q. Within the gynecologic pathology --
A. Yes.
Q. -- correct?
A. Yes.
Q. What did that course entail?
A. Oh, this is a medical student course, so it's about basic endometrial -- basic uterine service and vulvar and vaginal pathology.
Q. Okay.
A. That's what it's about.
Q. Any discussion of polypropylene in that course?
A. No.
Q. Mesh complications?
A. No.
Q. Transvaginal mesh?
A. No.

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Q. Have you taught any courses related to polypropylene ever?
A. No.
Q. Have you ever taught any courses related to transvaginal mesh?
A. No.
Q. Okay. On a copy of your CV that I have, it's page 26, you've listed quite a few articles where you have been an author, correct?
A. Correct.
Q. And I have it as number 71. The title of the article is "Ovarian Carcinosarcomas Associated with Prolonged use of Tamoxifen."
A. Correct.
Q. Do you have -- and that was published in 2009?
A. Correct.
Q. Do you have a recall of the subject matter of that article?
A. I think it was a report of some ovarian carcinosarcomas that occurred in patients who had been using Tamoxifen basically.
Q. And what is Tamoxifen?
A. It's a -- it's a hormonal -- really more agonist, slash, antagonist for estrogen that's being treated -- women with breast cancer are treated with.

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Q. Is it a drug that's been cleared by the FDA?
A. Yes.
Q. It's been on the market for 40 years, thereabout?
MR. WES: Object to form, foundation.
THE WITNESS: It's been on the market for a while.
MR. JONES: Q. Okay. And in what article did you find an association between Tamoxifen and ovarian sarcomas?
A. There was possible association between ovarian carcinosarcomas and Tamoxifen. And that was what he was reporting, the first author, Oscar Lavie.
Q. Okay. Did you also -- was there also a finding that in that article that it was a delayed response to the Tamoxifen?
A. I don't know that it's a -- a delayed occurrence. And actually probably not even delayed. I mean, it's basically prolonged use.
Q. Then you have listed some books and book chapters in preparation in your CV, correct?
A. Yes.
Q. And number one, you list yourself as chief editor of Gynecologic Pathology, eMedicine from WebMD, correct?
A. Yes.

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Q. Has that -- is that still in preparation, or has that been published yet?
A. It's still in preparation.
Q. Okay. Is there any discussion within that book of polypropylene?
A. No.
Q. Transvaginal mesh?
A. No.
Q. Mesh complications?
A. No.
Q. That's all the questions I have about your CV. You can put that away.
Do you specialize in how the body reacts to polypropylene?
MR. WES: Object to form.
THE WITNESS: As a pathologist I have expertise in interpreting tissue response to foreign material in general, and that would include polypropylene.
MR. JONES: Q. In your experience as a pathologist, are mesh explants stored in any type of material to preserve them?
A. They're often submitted -- because there's associated tissue at some level with them, they're often submitted in formalin fixative.
Q. Okay. Is that the customary practice that you

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see as a pathologist?
A. Yes.
Q. Do you have any opinions about that subject matter that you'll be giving in this case, specifically related to the formalin that it's preserved in?
MR. WES: Object to form, vague.
THE WITNESS: I think we touched a little bit on it earlier in that formalin shrinks tissue.
MR. JONES: Q. What about mesh? How does the formalin affect mesh?
MR. WES: Same objection.
THE WITNESS: I don't know how formalin necessarily affects mesh.
MR. JONES: Q. Okay.
A. To the extent that there's tissue attached, there would be shrinkage as well, but actual mesh material in interaction with formalin, I don't know.
Q. Will you be giving any opinions related to degradation of mesh in this case?
A. No, I will not.
MR. WES: Object to form, outside the scope.
MR. JONES: Q. I want to ask you a series of questions about your experience as a litigation consultant or expert.
Can you give an estimate of how many depositions

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you've given in your role as an expert witness?
A. I think less than 50, but it may be somewhere in that range.
Q. How many times have you testified at trial?
A. Maybe half a dozen. Not that often.
Q. Do your fees for your litigation consulting and expert work make up a significant amount of your salary and revenue?
A. No.
Q. Have you ever acted as an expert prior to this case on transvaginal mesh?
A. No.
Q. Hernia mesh?
A. No.
Q. Have you ever worked for Johnson & Johnson prior to this case?
A. I don't think so, but it's a big company with a bunch of subsidiaries so...
Q. It is.
A. But not that I know.
Q. How about Ethicon?
A. No.
Q. In this case did you conduct any testing yourself?
A. Other than that S-100 immunohistochemical stain,

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no.
Q. Are there peroxides that are naturally present inside the vagina?
A. I'm not sure what that -- what you're asking.
Q. Okay. Is the vagina a highly acidic area?
MR. WES: Object to form.
THE WITNESS: It has a low ph. I don't know if it's highly acidic. And the ph can change depending upon the flora that's there and whether patients taking antibiotic use, et cetera.
MR. JONES: Q. Do you have expertise in the flora or peroxides or ph balance of the vagina?
A. That's not --
MR. WES: Object to form.
THE WITNESS: -- within the realm of my opinion in this case.
MR. JONES: Q. Perfect. Does the inflammatory response of transvaginal mesh ever stop?
A. Well, so with any foreign body there will always -- to the best of my knowledge in all my experience, there's always a sort of persistent thin layer, and in some instances it may be even thicker of lymphocytes and macrophages associated with that foreign material. And that would include mesh, yes.
How active that is in terms of causing

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symptomatology is not so certain. The cells are obviously alive and viable, but how much they're really doing other than just standing guard, if you will.

Q. Okay. I'm going to name a few articles related to the inflammatory response to transvaginal mesh or hernia mesh and ask you if they ring a bell. Are you familiar with a Cobb article?

MR. WES: Object to form, foundation.

THE WITNESS: It would be so much easier if we had the articles.

MR. JONES: Q. If -- I'll tell you what. If -- once we get a list of the articles that you actually looked at, then I'd gladly be -- would ask you about those. But I'm just trying to get --

A. I know.

Q. Okay. Does the name Kosterhalfen ring any bells?

A. Yes, that does.

Q. Okay.

MR. WES: Same objection.

MR. JONES: Q. What's your recall of Bernard Kosterhalfen?

A. I'm not sure right now. I don't remember.

Q. It's a pretty unique name, and it rings a bell --

A. Yes.

Q. -- and you know you've reviewed something related

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to Klosterhalfen?

A. I think I have, yes.

Q. We talked about Iakolov, I-A-K-O-L-O-V, perhaps on the spelling. He's a pathologist who has written some articles related to transvaginal mesh. Does that ring a bell at all?

MR. WES: Object to form.

THE WITNESS: It's not ringing any bell right now, but it doesn't mean I didn't review it. But I don't -- I don't recollect it right now.

MR. JONES: Q. What about Todd Heniford?

MR. WES: Object to form, foundation.

THE WITNESS: Again, I'm not sure about the name.

MR. JONES: Q. What about Uwe Klinge?

MR. WES: Same objections.

THE WITNESS: That name is familiar.

MR. JONES: Q. Okay.

A. This is Klinge?

Q. Yes.

A. Yes.

Q. Are you aware that polypropylene is used in products besides transvaginal mesh?

A. Yes.

Q. Do you know what products -- can you name a few products in which polypropylene is used in besides

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transvaginal mesh?

MR. WES: Object to form, outside the scope.

THE WITNESS: Well, polypropylene is used in suture material and other mesh materials and maybe other things, but those are the only two that come to mind right now.

MR. JONES: Q. Okay. Do you know if it's used in fishing line?

MR. WES: Same objection.

THE WITNESS: My son would know.

MR. JONES: I'll move on.

Q. Will you be giving any opinions related to cytotoxicity in this case?

MR. WES: Object to form.

THE WITNESS: Not -- no, not -- other than what I've already talked about in terms of the inflammatory response, no, not specifically.

MR. JONES: Q. Did you review any Ethicon testing related to the cytotoxicity of the mesh used in the TVT Abbrevo device?

A. No.

MR. WES: Object to form, outside the scope.

THE WITNESS: And no, I don't recall specifically reviewing any cytotoxicity.

MR. JONES: Q. Would cytotoxicity testing of the

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mesh used in the TVT Abbrevo device be something that you would want to look at in helping you form your opinions in this case?

MR. WES: Object to form, outside the scope.

THE WITNESS: No, it wouldn't -- I don't think that would have any influence on my opinions on the slides and the tissue, no.

MR. JONES: Q. Did you keep any notes when you worked on this case?

A. No.

Q. Any e-mail folders that you created specifically in response to this case?

A. No.

Q. Any file folders?

A. No. I have boxes with these but no file folders.

Q. Are you a paper person or an electronic person when you reviewed these deposition testimony, medical records?

MR. WES: Object to form.

THE WITNESS: Mostly I've read the paper.

MR. JONES: Q. Did anybody help you work on this case?

A. No.

Q. No assistants?

A. No.

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Q. Or fellow doctors?
A. No.
Q. Have you set up a corporation to accept payments for your litigation consulting work?
A. No.
Q. Before rendering your opinions in this case, did you speak with any pelvic floor surgeons at Stanford University?
A. No.
Q. Do you know of any of the pelvic floor surgeons at Stanford University?
A. Yes.
Q. I mean, you're aware that Stanford has a highly respected pelvic floor surgery clinic, correct?
A. I would suspect they do.
Q. With well respected surgeons who make up that clinic, right?
MR. WES: Object to form.
MR. JONES: Q. Do you know Lisa Rogo-Gupta?
A. No, I don't know her.
Q. Okay. Didn't talk to her at all --
A. No.
Q. -- before you gave your opinions in this case?
A. Don't even know her.
Q. How about Eric Sokol?

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A. I know of him, yes.
Q. Did you talk to him before you rendered your opinions in this case?
A. No.
Q. Do you have any knowledge of his work on transvaginal mesh?
A. No.
Q. You didn't review any articles he wrote about transvaginal mesh?
A. No.
Q. We talked about Dr. Margolis earlier. You're familiar with Dr. Margolis in that you've read his deposition, correct?
MR. WES: Object to form, misstates the testimony.
MR. JONES: I'll rephrase the question.
Q. You're familiar with Dr. Margolis in that you've reviewed pictures Dr. Margolis took of Ms. Perry?
A. Yes.
Q. Did you know Dr. Margolis used to work at Stanford University?
A. Yes, I did.
Q. Do you know Dr. Margolis?
A. I've interacted with him.
Q. What do those interactions entail?

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A. Oh, he operated on occasion at Stanford.
Q. Okay.
A. And I'm a GYN pathologist.
Q. So you worked with him?
A. I don't know about with him, but I -- you know, I received pathology materials that he removed.
Q. What pathology materials were those?
A. Oh, I don't remember. They were GYN path, but that was so long ago, I don't remember. And there were discussions that I had, but I have no recollection of the contents of them. But I definitely remembered him as being a surgeon that was at Stanford.
Q. Do you have any criticisms of his expertise in the field of urogynecology?
MR. WES: Object to form, foundation.
THE WITNESS: He's not an expert in GYN pathology.
MR. JONES: Q. Any other criticisms?
MR. WES: Same objection.
THE WITNESS: Nothing that I want to say right now.
MR. JONES: Q. Right now. Are these criticisms that you might share at trial?
A. No.
Q. You just want to keep those personal, to

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yourself?
A. I think so.
Q. You realize he set up the urogynecological -- urogynecology and pelvic reconstructive surgery clinic at Stanford, correct?
A. No, I didn't realize that.
Q. You didn't know that?
A. No.
MR. WES: Can I get an objection, form, foundation on the last one?
MR. JONES: Q. And you know that Dr. Margolis is an expert witness for the plaintiff in this case?
A. Yes, I do know that.
Q. Okay. Are you aware of whether or not the Stanford urogynecology clinic specializes in treating mesh complications?
MR. WES: Same objection.
THE WITNESS: No, I'm not aware of that.
MR. JONES: Q. Have you reviewed any videos posted by the Stanford urogynecology clinic that have been posted online?
A. I don't think so.
Q. Okay. Did you notify the pathology department at Stanford that you would be acting as an expert in this case?

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A. No.
Q. Do any other doctors at Stanford know that you're acting as an expert in this case?
A. No, I don't think they do.
Q. I want to go back to real quickly -- we talked about smoking and diet and diabetes earlier and how it relates to wound healing, and I want to focus on the diet.
Have you reviewed records in this case related to Ms. Perry that discuss certain diets she was on?
A. Yes.
Q. And what did those records say?
MR. WES: Object to form. The records will speak for themselves.
MR. JONES: Q. Do you have any recollection of it?
A. I do recall it, yes. It was -- sounded like an odd diet to me.
Q. An odd diet?
A. And it sounded -- yeah, but most diets sound a little odd to me, to be quite honest, so -- but yeah, she was on a -- some special diet that she was trying to reduce her weight, correct.
Q. Okay.
A. And it looked to me like it was really quite low on the calories.

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Q. Oh, very low calorie intake diet?
A. Yes.
Q. How you about protein? Was there a focus on the amount of protein in her diet?
MR. WES: Object to form, foundation, calls for speculation.
THE WITNESS: Yeah, I don't really specifically recall what all the components of the diet were.
MR. JONES: Q. But you do specifically recall it was a low calorie intake diet?
A. Yes.
Q. She was trying to reduce her weight?
A. Yes.
Q. And it was what you phrased as an odd diet?
A. Yes.
Q. And it's your opinion that that diet affected her ability to heal the wound from the TVT Abbrevo device?
MR. WES: Object to form.
THE WITNESS: It's my opinion that that significant reduction in calorie intake when she was having post surgery and wound repair may well have affected the healing, yes.
MR. JONES: Q. It may well have not have affected the healing, though, too, right?
MR. WES: Object to form, argumentative.

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THE WITNESS: I think in all likelihood that it did contribute.
MR. JONES: Q. It's possible that it didn't contribute, though, right?
A. Of course.
Q. It's possible that her smoking, you know, two cigarettes a week did not affect her healing capacity, correct?
MR. WES: Object to form.
THE WITNESS: It's -- yes, it is possible.
MR. JONES: Q. It's also possible that diabetes didn't impact the wound healing at all, correct?
MR. WES: Object to form.
THE WITNESS: Yes. All of these things are possible, but are we talking about possible or likely? And I think that these are all factors that have been established to impair wound healing, and if they're active in a particular patient who is having problems with wound healing, one would suspect that in all likelihood they were contributory factors.
And that's sort of how medicine works. It's not an all or none absolute science. It's not like the non-medical sciences.
MR. JONES: Q. Not two plus two equals four?
A. Exactly. It's not mathematical.

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Q. Did you focus at all -- when you looked at her diet in the association to wound healing, did you focus at all on the amount of protein in her diet?
A. Not specifically.
Q. Okay. Protein -- the amount of protein in your diet is related to wound healing as well, right?
A. Oh, of course. Lots of things. But protein's important as well, yes.
Q. Do you have any recall of her not getting proper amount of protein in her diet?
MR. WES: Object to form, foundation.
THE WITNESS: No, I can't address whether or not she had sufficient protein in her diet.
MR. JONES: Q. When she was on this diet, was she malnutritioned?
MR. WES: Same objection.
THE WITNESS: I'm not sure what you mean by "malnutritioned." She may not have been given all the necessary nutrients.
MR. JONES: Q. Do you know one way or another whether she was getting the necessary amount of --
A. No.
Q. -- nutrients?
MR. WES: Same objection.
MR. JONES: Q. You're not a nutritionist, right?

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A. Exactly.
Q. So that's outside of the field of your expertise?
A. Correct. Well --
Q. Whether she was --
A. -- specific nutritional questions are not part of my opinion.
Q. Whether she was getting an adequate amount of nutrients in her diet is outside the field of your expertise?
MR. WES: Object to form.
THE WITNESS: So my opinion is that she's got inadequate wound healing. Let's just reiterate that -- or insufficient. That wound is not healing. And what were the possible causes?
One of them might be this drastic diet she went on. It's a pretty significant cut in calories, I suspect, for her, and that may have been a contributing factor. And I stand by that.
Now, if you bring a nutritionist in and they say, well, that should be enough, it may be enough for somebody who is not trying to heal a wound, who is not diabetic, who is not with all these other factors. I think it gets to be a complicated issue, but that is an added insult in somebody who is already trying to heal postsurgical.
In fact, they tell you to increase your nutrition

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because surgery -- any kind of -- this isn't that major of a surgery, I admit, but any kind of procedure actually increases catabolism so...
MR. JONES: Q. Whether or not Ms. Perry was getting an adequate amount of nutrients in her diet is outside the field of your expertise? Yes or no?
MR. WES: Object to form.
THE WITNESS: To the extent that I'm a physician, it's still within my area of expertise, but it's not my subspecialty, and I think that's what you're asking. So no, that's not something that I am a subspecialist in. It's not nutrition. That would be correct.
MR. JONES: Q. Okay. And you won't be giving an opinion that the diet Ms. Perry was on was not supplying her an adequate amount of nutrients, correct?
MR. WES: Object to form.
THE WITNESS: Adequate for what? See, that's the problem I'm having. Adequate for what?
MR. JONES: Q. Adequate for wound healing.
A. It may not have been.
MR. WES: Objection.
THE WITNESS: It may not have been.
MR. JONES: Q. Do you know the level of nutrients that she was getting in her diet?
MR. WES: Object to form, foundation.

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THE WITNESS: It's a matter of significant decrease as well as just the level. You know, physiologic, you know, you're sort of used to a certain level of intake. And when you do a drastic cut, that has a bigger effect than long term.
I mean, a certain amount of nutrients may be healthy at some level, but when you do these sudden cuts, the body doesn't adapt that quickly. That's my point.
MR. JONES: Q. Okay. It's not so much --
A. It's not --
Q. -- the amount of nutrients that she was getting, it's more the decrease in level of the nutrients perhaps due to the low calorie intake diet she was on?
A. Yes.
Q. Okay.
A. So that diet may be totally, although it seems odd, healthy, but I still say these sudden cuts are, you know -- those are the things -- a body doesn't react that fast to those. It takes awhile to get back to steady state, and that sudden drop could -- could impair wound healing, could impair -- you know, resistant to infection, all sorts of things, colds.
Q. Could it cause an erosion of the mesh?
MR. WES: Object to form.
THE WITNESS: Yeah, because I'm not sure what you

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mean by "erosion of the mesh."
MR. JONES: Q. So in this case Ms. Perry was implanted with mesh?
A. Correct.
Q. And that mesh eroded through her vaginal tissue, correct?
MR. WES: Object to form.
THE WITNESS: Well, see, that's -- yeah, that's kind of -- I think that's sort of the crux of the issue is that really -- I mean, what is mesh erosion and what causes that? And I'm not a hundred percent clear that I even understand that reading all the literature about that.
Does mesh eventually come up against the vaginal tissues and erode or present itself? Yes, that is. But what's causing that? And in this particular case, the tissue that was removed, as I mentioned, shows a non-healing wound in the vaginal area of the mucosa, but beneath that is an area of submucosal, the normal submucosal in vaginal tissue that looks fine. And then the next layer down is where you see the mesh.
So it's not clear that that mesh eroding up is what caused or was even causally related. In fact, I would argue it's not to that mucosal disruption. I think that's postsurgical wound healing that didn't

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heal.
MR. JONES: Q. Okay.
A. Now, that may have eventually, you know -- because when you have a non-healing wound, you end up getting a little bit of a depression, and that may have caused that mesh to become closer approximated to that -- to the -- you know, the vaginal lumen.
But you know, the mesh moving up and eroding the mucosa, I don't think that's what happened in this case. I think it's more that there's a non-healing wound, and eventually that mesh, you know, because of the non-healing wound became more approximated to the surface of the vagina.
Q. You say you reviewed literature related to mesh erosions, right?
A. Yes.
Q. Okay. Fair to say that mesh has eroded in women who don't smoke?
MR. WES: Object to form, outside the scope.
THE WITNESS: So yeah, it's not -- he's telling us he's trying to say it's not part of my opinion. I think that's fair to say, but yeah, I'm not sure I've seen a very nice well-designed study for erosion and, you know, pathologic examination and risk factors. I don't think that that exists in the literature.

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MR. JONES: Q. Okay. You talked earlier about why Ms. Perry had the mesh explanted, and you said Ms. Perry wanted it explanted and Mr. Perry wanted it explanted. You didn't say Mr. Perry wanted it explanted, but you made a reference to Mr. Perry, right?
A. Correct.
MR. WES: Object to form.
MR. JONES: Q. Okay. And flush that out. Explain what you meant when you brought up Mr. Perry related to the explant surgery.
A. Well, when Mrs. Perry presented back to her physicians with her complaints of pain, there were two issues, one, that her husband was complaining of pain during intercourse of it shafted his penis, feeling something in the -- her anterior vaginal wall. That was his pain.
Her pain was pain on entry predominantly, dyspareunia.
Q. In your literature review of mesh erosions, did you see references that -- to mesh causing pain?
A. I'm sorry, would you repeat that question?
Q. Yeah. You reviewed literature related to mesh erosions, right?
A. Yes.
Q. Within your literature review, did you see

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findings in the literature that transvaginal mesh caused pain in women?
MR. WES: Object to form, outside the scope, foundation.
THE WITNESS: There are a lot of papers discussing pain in association with the transvaginal mesh.
MR. JONES: Q. Okay.
A. And possible hypotheses about what might be causing that pain, yes.
Q. Same for dyspareunia?
A. Yes.
Q. And you're aware that there's mesh still inside of Ms. Perry, correct?
A. Yes.
Q. And you're aware that that mesh could erode again, correct?
MR. WES: Object to form, foundation, calls for speculation, outside the scope.
MR. JONES: Q. Will you be giving any opinions about recurring erosions in this case?
MR. WES: Same objections.
THE WITNESS: I don't think so. I'm not sure. Again, I'm not really sure what the question is.
MR. JONES: Q. Well, you've made -- you've given opinions related to the wound healing following her mesh

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procedure, correct?
A. Correct.
Q. And you understand the mesh is still inside of her, correct?
A. Correct.
Q. So your opinions related to the wound healing following the mesh procedure are not going to be applicable to any future mesh complications, correct?
MR. WES: Object to form, foundation, calls for speculation.
THE WITNESS: Assuming there's no further problems with wound healing, then I would expect -- I guess I'm not still sure what you're asking me.
MR. JONES: Q. Could there be wound healing impairment in the future for Ms. Perry?
A. There might be, yes. I mean, she's already demonstrated impaired wound healing once, so it's possible that it could happen again. She did have a second surgical procedure presumably that is now well healed and won't break down again, but I don't -- you know, I can't say for certain that it wouldn't.
It appears to me that based on at least the preliminary review of records that it was healing.
Q. Have you ever had your opinions excluded by any jurisdiction?

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A. No, I don't think so.
Q. Okay.
A. What does that mean when you're asking me that?
Q. Have you ever offered opinions in a case and the judge has come back and excluded your opinions because they weren't relevant to the case?
A. No. No.
Q. Has a judge ever excluded your opinions on the bases of your lack of expertise?
A. No.
Q. Has the -- has a judge ever excluded your opinions on the bases that you've given opinions outside of the field of your expertise?
A. No.
Q. Okay. Will you be giving any opinions in this case as to industry bias in the medical device marketplace?
A. No.
MR. WES: Object to form, outside the scope.
MR. JONES: Q. Will you be giving any opinions as to industry bias in the medical literature?
MR. WES: Same objection.
THE WITNESS: No.
MR. JONES: Q. And when you reviewed the medical literature in this case, did you look and examine the bias

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of the authors?
MR. WES: Same objection. Also, foundation, calls for speculation.
THE WITNESS: I wouldn't use the word "bias," but generally when I review any scientific paper, I try to take note of who the authors are even though obviously I can't always recall their names but the centers that they're associated with.
I also pay attention to the journal that it's published in, whether peer reviewed, and if I can discern whether it's a respected journal. They have different levels of peer review journals.
So yes, I do that. And that's probably a better way than just call it bias because we want to be sure that people are presenting good data.
Q. The reason why you examine all those factors that you discussed because it helps you form a judgment as to the reliability of the findings in the article, correct?
A. Correct.
MR. WES: Object to form.
MR. JONES: Q. And -- and do you examine -- strike that.
A. Wait --
Q. It's something that you would -- go ahead.
A. So wait a second. Why don't you -- repeat that

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question again that he just asked and I responded to about the reliability of what?
Yeah, can you read that back?
(Record read.)
THE WITNESS: Okay. So I want to correct -- answer that. The findings may be -- it's more -- it could be the findings, but it also would be the -- sort of the scientific evidence supporting their conclusions.
MR. JONES: Q. Okay.
A. Right. So some of the opinions stated kind of -- that's based on their findings in part but --
Q. One of the things you look at --
A. So it's all of that. It's the entire package. It's not just the -- you know, the result section. It would be all of that. Okay.
Q. You want as much information as reasonably possible to assess the data in the article that you're reviewing?
A. Yes.
Q. And one of the pieces of information you would want is whether the authors were being paid by the company marketing the device that they're studying?
MR. WES: Object to form.
MR. JONES: Q. Correct?
MR. WES: Foundation.

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THE WITNESS: I pay -- I pay attention to those issues as well, yes. That doesn't necessarily imply that their findings are unreliable, but no, I definitely pay attention to those things.
MR. JONES: Q. But it's something you would want to know absolutely?
A. Yes. Yes.
Q. And when you reviewed literature, you talked about long-term studies earlier, correct?
A. Correct.
Q. Did you notice anything in those long-term studies where the authors were paid by companies that were marketing the very products that were discussed in the study?
MR. WES: Object to form, foundation, outside the scope.
THE WITNESS: Yes. So no, there are -- there were -- I don't recall specific -- which specifics, but there certainly are some of those, and that happens in all the literature of course.
MR. JONES: Q. And did you examine whether the authors in some of those long-term studies were the inventors of the products that they were reporting on?
MR. WES: Same objections.
MR. JONES: Why would it be important when you're

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reviewing medical literature to help form your opinions in this case to examine if the authors were, in fact, the inventors of the product they were reporting on?

MR. WES: Object to form, foundation, calls for speculation.

THE WITNESS: Well, it always places things in context, but you know, other than that -- yeah, you know, it's good to know these things, but they don't necessarily impact -- they may, but they don't necessarily impact the validity or dis-validity, if you will, of their findings.

MR. JONES: Q. When you've served on editorial boards for medical journals, have you required that the author submit disclosures related to how much money they've been paid by companies that they're reporting on?

A. Yes.

MR. WES: Object to form.

THE WITNESS: All the journals that I review require disclosures. I don't know that if it's the exact dollar amount, but you know, full disclosure is required before publication.

MR. JONES: Q. Have you made comments online related to industry bias in the medical device marketplace?

MR. WES: Object to form, foundation, outside the scope.

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THE WITNESS: No.

MR. JONES: Q. You haven't?

A. No.

Q. Okay. Do you have social media accounts?

A. No.

Q. You don't?

A. No. Well, what do you mean? Which kind?

Q. Are you on Twitter?

A. No. No.

Q. Okay. Facebook?

A. No.

Q. LinkedIn?

A. Yes.

Q. Okay. Have you made any comments online related to concerns about marketing in the medical device marketplace?

MR. WES: Object to form, foundation, outside the scope.

THE WITNESS: No.

MR. JONES: Okay. I think that may be all the questions I have. I want to go off record, take a ten-minute break and then sounds like there may be some more questions. We'll go figure that out. Does that sound like a good plan?

MR. WES: Sounds good.

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(Short break taken.)

MR. JONES: We're back on the record. That's all the questioning I have for you, Doctor. I'll now pass the witness.

EXAMINATION BY MS. COTA

MS. COTA: Q. Good afternoon, Doctor Longacre. My name is Laura Cota. I don't think I introduced myself earlier. I apologize for that. Our firm represents Dr. Luu in this matter, and I have just a few questions for you. I'm going to try not to repeat any of the questions that counsel has already asked, but I may. And if I do, I'm going to apologize for that in advance.

We spoke in the beginning of counsel's questioning about the documents you have reviewed in your work on this case, and I just want to clarify, you mentioned that you've reviewed some of plaintiff's medical records. Did you review the plaintiff's record -- or I'm sorry, Ms. Perry -- Ms. Perry's records from Dr. Luu?

A. Yes, I did.

Q. And did you review Dr. Luu's complete chart for Ms. Perry or just portions of it?

A. I think I reviewed most, if not all, of the chart. I think I was given most of it, and I think I reviewed most of it.

Q. Okay. And how about -- are you familiar with

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Dr. Allen and his involvement with Ms. Perry?

A. Yes.

Q. And did you review Dr. Allen's chart of Ms. Perry?

A. Yes.

Q. And how about Dr. Singh? Are you aware of Dr. Singh's involvement with Ms. Perry?

A. Yes.

Q. And did you review Dr. Singh's chart --

A. Yes.

Q. -- of Ms. Perry?

A. Yes, I did.

Q. And you're aware that Ms. Perry had the procedure performed by Dr. Luu at San Joaquin Community Hospital?

A. I don't specifically remember the name of the hospital.

Q. Do you recall if you reviewed the hospital records pertaining to Ms. Perry's procedures performed Dr. Luu?

A. I may have briefly reviewed them.

Q. Okay. And we talked a little bit about deposition transcripts, and I know you said you reviewed Ms. Perry's and her husband's deposition transcripts.

Did you review Dr. Luu's deposition transcript?

A. Yes, I did sometime ago.

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Q. Do you recall how long ago that might have been?
A. A month or so ago.
Q. Okay. And how about Dr. Allen? Did you review his deposition transcript?
A. Yes.
Q. And was that the same amount of time ago, about a month and a half ago?
A. I think that was a little more recent. I think that came in after Dr. Luu's.
Q. Okay. And Dr. Singh, did you review his deposition transcript?
A. Yes.
Q. And how long ago did you review Dr. Singh's deposition transcript?
A. A month or so ago.
Q. Okay. And I believe you testified you have not reviewed Dr. Margolis's deposition transcript?
A. Correct. I've had portions of it relayed to me, but I have not reviewed it. I'm not even sure I received it.
Q. Okay. Do you know what portions of his transcript have been forwarded to you?
A. None were forwarded. I was just read a few --
Q. And what portions of Dr. Margolis's deposition testimony were read to you? If you can give me sort of a

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summary.
A. I think that he was discussing shrinkage of the mesh and he discussed the pathology report at some point and it was that discussion.
Q. Okay. And the pathology report he discussed, was it the -- the pathology report that you've referred to as the -- from the -- I'm sorry, give me one second -- the posterior repair procedure? Was it that pathology report?
A. No. I think he was mostly just -- at least the parts that were relayed to me was discussing the explant --
Q. Explant?
A. -- tissue, yes.
Q. Okay. And I'm sorry, I know counsel asked you this, but I'm not sure what the response was. Dr. Margolis, he prepared a report of his independent medical exam of Ms. Perry. Have you reviewed that report?
A. I may have reviewed that, but I don't -- I don't have a clear memory of that.
Q. Okay. Do you recall if any of the deposition transcript portions that were read to you from Dr. Margolis's deposition referred to his report?
A. No, I don't recall that.
Q. And Dr. Longacre, I'm going to refer to -- I believe it's Exhibit L-2. It's the pathology report that

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you had described as -- from the posterior repair procedure. It's the --
A. Yes.
Q. Okay. You got that?
Okay. What I'm looking at it says, "Tissue ID is vaginal wall posterior excision."
Can you tell me what -- in layman's terms what does that mean? What are we talking about?
A. Posterior vaginal wall. So mucosa and some of the submucosa.
Q. And that would have been taken from where?
A. The vagina.
Q. Can you be any more specific about the location that this sample would have been taken from?
A. Distal posterior vagina from my understanding of the surgical procedure.
Q. And do you know why the sample would have been taken?
MR. WES: Object to form.
THE WITNESS: This -- based on other medical records, he performed an anterior and posterior colporrhaphy procedure, and it was because there was a cystocele and rectocele.
MS. COTA: Q. And so the purpose was to determine the pathology of the cystocele and -- or --

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A. No. No, this is part of --
MR. WES: Object to form.
THE WITNESS: Again, my -- I'm not a surgeon. This is not -- but in terms of my receiving these specimens, my understanding of these procedures is that when -- they're basically removing excess tissues to sort of tighten it up because the rectocele is basically the rectum is protruding into the vaginal lumen causing prolapse.
And so by removing that redundant tissue, it's thought to help prevent that rectocele. Same thing for the cystocele, but that would be the anterior vaginal mucosa.
MS. COTA: Q. Okay. And so is this just a standard procedure to your knowledge?
A. What --
MR. WES: Object to form.
MS. COTA: Q. To, I guess, get a sample to pathology to review in this instance?
A. Most -- most hospitals require their surgeons to submit all tissue that's removed from patients to pathology.
Q. Okay.
A. Yes. That part is standard.
Q. Okay.

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A. Some hospitals don't have the explicit requirement as others do.
Q. Okay. Very good. Thank you for clarifying that.
And as part of Dr. Luu's chart, did you review Dr. Luu's operative report of Ms. Perry's procedures? I believe they're on March 23rd of 2011.
A. I'm sorry, did I review the operative procedure? Yes.
Q. Okay. So you read Dr. Luu's operative report?
A. Yes.
Q. And do we know when during this procedure the sample that we're talking about in this pathology report would have been obtained?
A. I have the report here. I guess I'm not sure. What do you mean when was it obtained?
Q. Do you know when during Dr. Luu's procedures this sample would have been obtained?
MR. WES: Object to form, foundation, calls for speculation.
THE WITNESS: Short of reading this report, I wouldn't know.
MS. COTA: Q. Okay. Well, that's fine. We'll move on.
I believe, Dr. Longacre, you testified earlier that -- or actually, it says here in your report that

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there are no gross findings because nothing but slides were reviewed by you.
A. Correct.
Q. And is it true that based on the pathology report -- and I apologize I cannot read this physician's name -- this physician would have actually viewed the actual sample?
MR. WES: Object, form, calls for speculation.
THE WITNESS: Well, no, there is a gross description in the pathology report from the pathologist.
MS. COTA: Q. And so that means that this physician actually viewed the sample?
MR. WES: Same objection. Also, foundational.
THE WITNESS: Well, actually that's not the case. The gross description was dictated by one physician, whereas the diagnosis was signed out -- is rendered by a different physician.
MS. COTA: Q. Okay. But based on this pathology report somebody -- some physician --
A. Yes.
Q. -- viewed the actual sample?
A. Correct.
Q. Okay. Thank you. And moving on to your list of opinions on page 2 -- and thank you for providing this for us. It made it a lot easier and probably more expedient

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for us.
A. Okay. I don't have mine. I don't know why. Do I? Oh, nope. Here it is. Go ahead.
Q. Okay. Page 2. And if we look at -- let's see -- subsection C, number two, where it says, "Fragments of hair bearing skin from perineum."
Can you explain how do you know that that's what you were looking at? How do you identify skin from the perineum?
A. So that's a fair question. Basically I was trying to distinguish vaginal mucosa from cutaneous tissue, and that's how I knew. I mean, it wasn't just vaginal mucosa that was in the specimen, because that looks different from skin.
Now, because this is a posterior colporrhaphy procedure, the skin would be the perineum. It should be. If I knew -- how do I distinguish -- if somebody gave me a slide from perineum and a slide from maybe the buttock, would I be able to tell the difference? No. It's skin.
But there was no reason he would be taking skin from someplace else. If he's taking it -- if the surgeon's removing skin, it would have been in the perineal region.
Q. And further, what is the perineum?
A. It's the skin -- in this particular case it would

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be the skin immediately posterior to the vaginal -- to the introitus, the vaginal opening.
Q. And so your description here of it being from the perineum is because of -- is based on the procedure that Dr. Luu performed?
A. Yes. It's contextual. I can tell that it's perineum as opposed to vaginal mucosa because there's hair and sebaceous glands, and you don't see that in vaginal tissue.
Q. Okay. But like you said, you wouldn't be able to differentiate -- if you didn't know what it was, you wouldn't be able to differentiate skin from the perineum with skin from -- I think your example was the buttock?
A. Correct.
Q. Okay. In your looking at the samples, was it obvious to you that there was something other than mucosal tissue on the slide, in the sample?
MR. WES: Object to form.
THE WITNESS: Yes.
MS. COTA: Q. Okay. And then moving down to subsection D. And let's see. On -- I guess this is little -- little i, 1, where it says, "Hair bearing skin," et cetera.
Can you, as Counsel would say, flush that out for me and just explain what that means and why it's

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important?
A. Again, it's just indicating that during -- that it wasn't just vaginal mucosal tissue that was removed, it was skin. It was cutaneous tissue. And again, by context it was -- it was the posterior perineal tissue.
And the reason I know that is because there were hair and there were sebaceous glands, and it was a little more edematous than -- both -- actually, both the vaginal tissue and the perineal tissue was a little more edematous than usual, but that's -- yeah, that's a soft finding, if you will. It's not surprising if she has prolapse, but it's not -- it's not an overly significant finding.
Q. Okay. And what does edematous mean?
A. Filled with fluid. It's not exactly it, but that -- you know, for a lay person, that's sort of what it means. If you have tissue protruding, it can be a little more edematous.
Q. Gotcha. Thank you. And you testified earlier -- and I'm looking at your points here. It the says 13 pieces were perineal -- I hate that word. I can't say it -- and the remainder eight pieces were of the mucosa.
So did you look at 21 slides altogether?
A. No. That was just the number of pieces of tissue that were on the slide -- on the slides in total.
Q. I see.

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A. So there were four blocks and in putting -- adding up all the pieces in each of those four slides that were made from the four blocks, there were that many fragments of tissue.
Q. Do you know if the entire sample was -- I don't know what the right word is -- prepared and placed on slides?
MR. WES: Object to form, foundation, calls for speculation.
THE WITNESS: So do I know for -- personally because, no, I didn't do the gross. But based on the path report, it says, "Sections all, four cassettes." That generally means all the tissue was submitted. That's what that should mean.
If they meant something else, then it's not -- it's a miscommunication. Generally when we say all, all the tissue's been submitted.
MR. COTA: Q. Okay. Do you know if you have viewed all of the tissue from the sample that was submitted?
A. Four cassettes were made, and so there were four sets of slides, so that should be all of the slides of the tissue.
Now, you could cut additional -- there's still tissue in the blocks, in the paraffin blocks, and you

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could theoretically cut more sections.
Q. Okay.
A. So it's not like every --
MR. WES: Previous objections.
MS. COTA: Q. So you haven't looked at the entire sample? Is that fair to say?
MR. WES: Same objections.
THE WITNESS: I'm not sure. No, I don't think that's fair to say because I'm not even sure what you're asking.
MS. COTA: Q. Well, I think you talked about the sample they take and cut and make -- prepare slides out of the blocks.
A. Yes.
Q. Do you know if you've viewed -- like if all the material has been prepared as slides?
A. No. I don't know that.
Q. Okay. So it could be that there's portions of the sample that you haven't looked at?
MR. WES: Same objections.
THE WITNESS: There will be -- no. You know, what's going to be left is additional level sections of that tissue, but there's not going to be suddenly another piece of tissue that I didn't see. That's highly unlikely. That would be not good pathology practice.

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You're supposed to cut into your block enough that you've seen all the -- that the pathologist has viewed all the tissue on those slides. So --
MS. COTA: Q. Okay.
A. So there may be additional levels, but there won't be -- there should not be more tissue that I didn't see.
Q. I see. And so would each slide have the four levels that you described, the mucosa, the submucosa, the muscularis and the adventitia?
A. Not necessarily. Most of them just have mucosa and submucosa.
Q. Okay. And the skin from the perineum, where would -- so that was along with the mucosa or the submucosa level that you saw?
A. No. No. It's another piece of tissue. And then we'll have skin. Then you don't call it -- it's not mucosae. You call it epidermis and then dermis --
Q. Okay.
A. -- which is the cutaneous correlate for mucosa and submucosa.
Q. Gotcha. Okay. Thanks.
A. There was -- most of the fragments were really distinct. They were either skin or vaginal mucosa. As I recall, there was one fragment where most of the tissue

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was vaginal mucosa, and then it transitioned into the skin.

So obviously he had taken tissue right at the junction of the vaginal mucosa and the skin, again -- arguing, again, that it is, in fact, perineum because they're actually connected.

Q. Okay. And I believe you testified that the -- I could be misstating this, but that the slides you were looking at there was some degradation from the process or something along those lines?

A. No, not degradation.

MR. WES: Objection, form, misstates the testimony.

THE WITNESS: Yes. So there's no degradation. There's no disruption. There's no interpretive issues with the initial tissue that was removed during the insertion of the mesh. It was the mesh -- the second procedure when the mesh was removed, that tissue was fairly disrupted.

MS. COTA: Q. Okay. Okay. I was confusing two words and two different pathology reports.

And I know you're familiar with Ms. Perry's statements in her deposition and her medical records. Have you reviewed any of her responses to any discovery requests that have been made in this case?

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A. I'm -- I don't know 'cause I'm not sure what you're asking. I don't know what discovery means.

Q. Okay. Right. Typically we lawyers, you know, have to ask lots of questions, and one thing we do in preparing for trial is send written questions to the different parties in the case. And then it's -- you know, the party has to respond to them.

I'm just wondering if your counsel had provided any of Ms. Perry's responses to any of those requests to you to review?

A. They may have. I've seen other material.

Q. Okay. But as far as knowing whether or not they're discovery responses, you wouldn't be able to tell me?

A. No.

Q. Okay. Do you know, as we sit here today, if Ms. Perry continues to complain of pain?

A. My understanding is that she is.

Q. Okay. And you reviewed Dr. Allen's records, so I know that you are aware that she had a portion of the mesh excised, I believe, in January of 2012; is that right?

A. Correct. I believe that's when it was.

Q. Okay. And are you aware that during the excision procedure that Dr. Allen also performed a procedure to basically widen the entrance or the circumference of the

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introitus?

A. Yes.

Q. But Ms. Perry continues to complain of pain; is that right?

MR. WES: Object to form, calls for speculation, foundation, outside the scope.

MS. COTA: Q. You can answer.

A. My understanding is because I recently saw a document that she was, yes.

Q. Okay. And were you aware that in addition to the complaints of dyspareunia, she also has complained of vaginal pain?

MR. WES: Same objections.

THE WITNESS: Yes. I'm not sure what vaginal pain is, but yes.

MS. COTA: Q. Okay.

A. I understand that she has that. She says she has that.

Q. Okay. And is it your understanding that she continues to complain of vaginal pain, as we sit here today?

MR. WES: Same objections.

THE WITNESS: I don't know what she -- what's happening today, but I realize that there was -- so basically, yeah, I was actually pretty surprised because I

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thought post the mesh excision things were a lot better, and I saw documents that all her pain was gone. And then it was very recently that I was supplied with a document that she has pain again.

MS. COTA: Q. Okay.

A. It sounded -- I thought it had resolved on my first review of the postsurgical records.

Q. Okay. And were you aware that she also complains -- or complained -- yeah, we'll leave it as complain of pelvic pain.

MR. WES: Same objection.

THE WITNESS: Yeah, I'm not sure about the pelvic pain. I'm not so aware of that. I know there's other pain issues related to a motor vehicle accident and some back pain, but I don't -- other than that I don't know a lot about that.

MS. COTA: Q. Okay. But even since Dr. Allen's procedures to excise a portion of the mesh and also widen the introitus, Ms. Perry continues to complain of pain?

MR. WES: Objection, form, foundation, speculation, outside the scope.

MS. COTA: Q. You can answer.

A. Yeah, she's still complaining of some kind of pain -- or has started complaining again, I guess is what I would say, because I thought at some point she was

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reporting it was all resolved, and now it seems to have come back.
Q. And is that based on your review of her medical records?
A. Yes. The records that have been supplied by me, yeah.
Q. Okay. And I know you're aware of Dr. Margolis's reports, although you haven't had a chance to review it, the report of the IME. So --
A. The IME?
Q. Yes, the independent medical exam. I'm sorry.
A. Okay.
Q. Okay. So are you aware that in Dr. Margolis's report he writes that he is able to replicate or reproduce the plaintiff's pain complaints by palpating her vagina where the mesh is?
MR. WES: Objection, form, foundation, calls for speculation. This is outside the scope.
THE WITNESS: And I don't recall that. I'm not --
MS. COTA: Q. Okay. So you're not aware that Dr. Margolis wrote that in his independent medical exam report?
A. No, not specifically I'm not.
Q. Okay. And I know you mentioned earlier you read

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Patrick Perry's deposition transcript and talked about his complaints of pain, and I think you said that his complaints had to do with feeling something, I think you said, in the posterior or anterior portion of the vagina of material that he could feel on his penis; is that right?
MR. WES: Object to form, foundation, misstates the testimony.
THE WITNESS: I think it was something was irritating the shaft of his penis during intercourse.
MS. COTA: Q. Do you recall if he testified that it was -- felt like a Brillo pad?
A. That part I don't --
MR. WES: Same objection.
THE WITNESS: I don't really recall what -- his --
MS. COTA: Q. Okay.
A. -- analogy. I don't remember that.
Q. Okay. Do you recall if he testified that the narrow opening -- narrow introitus was causing him any pain?
MR. WES: Object to form.
THE WITNESS: I don't recall that.
MR. WES: Speculation.
THE WITNESS: No.

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MS. COTA: Q. And I believe you stated that in your opinion the plaintiff's complaints of pain were due to the colporrhapy procedure; is that right?
A. I think that her dyspareunia is likely due to the colporrhaphy and that narrowing.
Q. And what is that opinion based on?
A. It's a known complication of colporrhaphy, number one; and number two, there was a substantial amount of that perineal tissue that was removed. And the more of the perineal tissue, the more likely that there's going to be pain associated with that -- with a posterior colporrhaphy procedure. And that's -- I think that's pretty well established that there's a significant risk for that.
Q. And is that something you know from your practice as a pathologist?
A. Yes. Just -- well, practice as a GYN pathologist, yes.
Q. Okay. And is that based in any way on any of the material that you reviewed that was provided to you by counsel?
A. There were some -- there was some literature that was provided recently on complications of colporrhaphy, and they were actually provided after I made the observation there was an awful lot of perineal tissue.

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And I wondered if that was -- my first thought was maybe this is what's really causing her dyspareunia, and it was shortly thereafter they provided me with this literature.
Q. Okay. Hang on one second here.
A. And it also corroborates -- I believe Dr. Allen seemed to think that was part of it. I think he was attributing her pain to that as well.
Q. And that's from reading his deposition transcript or his medical records?
A. One or the other.
Q. And you spent some time telling us about the -- and I'm going to say this wrong -- is it a mucosal non-healing wound or a non-healing wound in the mucosa or --
A. Either way.
Q. Okay. Great.
A. Yeah.
Q. You talked about that. Could that have been causing Ms. Perry's pain?
MR. WES: Object to form.
THE WITNESS: It didn't sound like it. The kind of pain she was describing, the dyspareunia, did not sound like that that was -- because she was really just talking about pain on entry initially, and that didn't sound like it was anything to do with any kind of non-healing wound.

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MS. COTA: Q. In general, in a non-healing wound of the type you're describing, would that potentially cause someone to suffer some pain?
A. It may or may not. Again, you know, if you're -- yeah, it may not. If there's some level of vascular insufficiency that -- particularly in diabetics. Now, she's not the classic type I, but she has been diagnosed with type II. They can have wound healing problems, and they may not have the same -- they may not notice they have injury. Their sensation may not be there. So it's possible that, you know --
Q. And I'm sorry, you told us this earlier, and I said I wasn't going to do this, but when did you first start reviewing materials for this case?
A. It was mid or late summer --
Q. Okay.
A. -- of this year obviously.
Q. And when did you first look at any of the slides?
A. I think it was late summer.
Q. Summer. You mean August or September?
A. I think August.
Q. And did you look at all of the slides you reviewed all at once, or did that happen in stages?
A. There was stages, but I think -- no, I think I did -- I reviewed all the slides the first time, I

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believe. And then there was another set of recuts that I saw again, but they were recuts of the slides I had already seen, as far as I recall.
Q. Okay. So you were actually -- you saw all the slides for purposes of what they revealed to you in August of this year; is that right? That probably wasn't a good question.
MR. WES: Objection, form.
THE WITNESS: I think it was August.
MS. COTA: Q. Okay. And so was it at that time upon your review in August that you came to -- or formed your opinion that there were these fragments of the perineum?
MR. WES: Object to form.
MS. COTA: Q. I'm sorry, was that a yes?
A. Yes. At the time of my first review of the colporrhaphy tissue that was removed, yes, that was my opinion then.
Q. Okay. And prior to your review of the samples, had you received any literature regarding the potential risks or side effects of colporrhaphy procedures?
A. No. No. As I mentioned, those came after I made the observation that there was a significant amount of that perineal tissue that was removed.
Q. Okay. And Ms. Perry, she's complaining of pain

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other than the complaints of dyspareunia; is that right?
MR. WES: Objection, form, calls for speculation, foundation, outside the scope.
THE WITNESS: My understanding it's more recently she's complaining of different kinds of pain now, yes.
MS. COTA: Q. Okay. And do you have any opinion of what could be causing those complaints of pain?
MR. WES: Objection, outside the scope, calls for speculation.
THE WITNESS: Well, okay. So I -- my response is yes and no as to whether I have an opinion. I do think that post colporrhaphy, even when you try to, you know, fix the pain, that it's continuing and ongoing.
So even though Dr. Allen tried to dilate the -- you know, the expand the circumference and dilate the introitus, there's always a chance that it will -- the pain, the dyspareunia, will recur for lots of reasons, but one of them would just be that it just sort of narrows down again.
So I would suspect that if, in fact, she's redeveloped pain, that's probably still a component of that colporrhaphy procedure. But there are other components of that pain that I have no opinion, 'cause they don't really make sense to me. I don't understand why she has them.

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Q. Okay. And what --
A. So I can't address those.
Q. And what -- I'm sorry, were you finished?
A. Well, I think she said something about burning vaginal pain without -- just de novo. I don't understand that.
Q. Okay. Any other components of her pain that don't make sense to you?
A. Well, those are the only one that I recall. When I read it, it didn't make any -- I don't know what that means --
Q. Okay.
A. -- or how to explain that or even --
Q. And her -- what about her complaints of vaginal pain? Does that make any sense to you?
MR. WES: Same objections.
THE WITNESS: No, not really.
MS. COTA: Q. And pelvic pain?
A. Well, again --
MR. WES: Same objections.
THE WITNESS: Again, I don't recall reading about the pelvic. I don't know what she means by pelvic pain. So that I don't know.
MS. COTA: Q. Okay. If --
A. Pelvis is a big area, so I don't know where she's

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talking about or what that's referring to.
Q. Okay. So if you were aware that she -- or if she -- if you were aware that she was complaining of pelvic pain, you wouldn't know the cause of that; is that right?
A. I wouldn't --
MR. WES: Object to form, calls for speculation, outside the scope.
Go ahead.
MS. COTA: Q. You can answer.
A. No, I wouldn't know.
Q. Okay. And Dr. Longacre, I know you've testified and told us that, you know, these opinions, you know, constitute the opinions you'll be giving at trial.
Are you going to be expressing any opinion of Dr. Luu's procedures that he performed on Ms. Perry?
A. No.
Q. Are you going to be making any criticisms of the procedures that Dr. Luu performed on Ms. Perry?
A. No.
Q. Are you going to be making any criticisms about Dr. Luu?
A. No.
MS. COTA: Okay. Thank you very much. I don't have any more questions.

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EXAMINATION BY MR. JONES
MR. JONES: Q. A few issues. Doctor, you brought with you some materials today that you could refer to, correct?
A. Correct.
MR. JONES: I'd like to go ahead and mark those materials that we haven't already previously marked as Exhibit L-8 (sic).
MR. WES: Sure. I think those are going to be the two operative reports.
THE WITNESS: Yes. That's what they were.
MR. JONES: Okay. We'll mark those as Exhibit L --
MS. COTA: The last one I have is L-8, the CV.
MR. JONES: Mark L-9.
(Whereupon, Exhibits L-9 and L-10 were marked for identification.)
THE WITNESS: What happened to L-4?
MR. JONES: A couple of follow-up questions based on information that came about through Laura's questioning.
Well, first off, Josh, you're going to provide a narrow universe of materials that she has actually looked at and reviewed, correct?
MR. WES: Yes, we will provide you of the list to

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make clear exactly what is on that flash drive that has actually been reviewed.
MR. JONES: Versus what hadn't been reviewed?
MR. WES: Correct.
MR. JONES: Okay. Thank you.
Q. Doctor, you understand this trial is set to begin January 12th, 2015, correct?
A. Correct.
Q. And I assume you've cleared your schedule and you would be able to come and testify the month of January?
A. After the 12th, yes.
Q. You'll be able to testify?
A. Yes.
Q. Final question. Will you be giving an opinion that the AC procedure, anterior colporrhaphy procedure, the AC procedure, caused dyspareunia in Ms. Perry?
MR. WES: Object to form.
THE WITNESS: I think -- well, it was an anterior and posterior colporrhaphy, and it's generally the posterior colporrhaphy part that is thought to be associated with the dyspareunia, not necessarily the anterior colporrhaphy.
MR. JONES: Q. Will you be giving an opinion the PC procedure caused dyspareunia in Ms. Perry?
MR. WES: Object to form.

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THE WITNESS: In all likelihood I think that it did, yes.
MR. JONES: Q. Will you be giving that opinion at trial?
A. Yes, I will.
Q. Is that an opinion that's included in this summary of opinions list?
A. I don't know why I keep -- it may not be.
Did you find it? This is why we have this 'cause I can't even remember what I say let alone what I write down.
Oh, consistent with findings of the explanter of a tight band at the introitus. So that's consistent with Dr. Allen's findings, and I guess by extrapolation I was -- his interpretation that that was probably what was causing the dyspareunia. The literature suggests that, and that's how I'm interpreting it. So that's what that is.
Q. So consistent with findings of the explanter of a tight band at the introitus?
A. Yes.
Q. What you mean by that is you'll be giving an opinion at trial that the posterior repair caused dyspareunia in Ms. Perry?
MR. WES: Object to form.

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THE WITNESS: Yeah, I think -- the opinion is that there was a -- there wasn't just vaginal tissue removed, there was a fair amount -- significant amount of perineal tissue. That perineal tissue -- in all likelihood that -- the removal of that material in all likelihood caused the narrowing, and narrowing of the introitus is associated with dyspareunia.

So in all likelihood, I think that that is what's caused her dyspareunia, and that was her report of pain on entry. So I think that's corroborated by Dr. Allen's findings, and that's my opinion.

MR. JONES: Q. Okay. Are there any other conclusions that you'll be giving that aren't included in this summary of opinions?

A. No.

Q. Okay. And you said that counsel provided you literature related to dyspareunia being associated with colporrhaphy procedures, correct?

A. Yes.

MR. WES: Object to form.

MR. JONES: Q. Did counsel provide you any literature related to transvaginal mesh causing dyspareunia?

MR. WES: Object to form.

THE WITNESS: Counsel provided me a lot of

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literature about -- concerning dyspareunia associated with -- or with -- you know, associated with mesh, yes.

MR. JONES: Q. Okay. And once we get the list of materials that you actually are relying on in this case, we'll be able to look at that list and locate articles where transvaginal mesh has been associated with dyspareunia, correct?

MR. WES: Object to form.

THE WITNESS: Transvaginal mesh material that's been -- I reviewed articles that talked about pain associated with transvaginal mesh.

MR. JONES: Okay.

THE WITNESS: Yes.

MR. JONES: That's all the questions I have.

FURTHER EXAMINATION BY MS. COTA

MS. COTA: And I'm sorry, I have like two follow-up questions.

Q. Dr. Longacre, you testified that it's your opinion that the dyspareunia that Ms. Perry complains of is because of a narrow introitus caused by the PC procedure. Is that --

A. Yes.

Q. -- accurate?

MR. WES: Object to form.

MS. COTA: Thank you.

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Q. Do you know how -- how wide the introitus was following the PC procedure?

MR. WES: Object to form, foundation, speculation.

THE WITNESS: Dr. Allen makes a comment about how it's, you know, narrowed and how many fingers he could insert versus after he dilated it, yes.

MS. COTA: Q. Okay. Do you know how wide the introitus was prior to the PC procedure?

MR. WES: Same objection.

THE WITNESS: I don't know that it was reported in that operative report.

MS. COTA: Q Okay. So is that a no?

A. Well, I think as -- I think even Doctor -- I'm blocking on his name -- Luu?

Q. That's my client.

A. Is that how you pronounce his name?

Q. My client, yes.

A. I think as he mentioned it, if he had seen -- if there was an abnormality, he would have reported it. He mentioned that in his deposition. So if there had been an abnormally narrow introitus, that would have been in his op report.

He didn't say that specifically, but I know that during his deposition he was asked something, and he

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basically said it would be in there. If there was anything abnormal, it would have been in there.

So I would extrapolate that it wasn't abnormally narrow at the time he did his mesh procedure and probably wasn't, not with all that -- usually with lax tissue, it's usually not narrowed. The enterocele and the recto -- cystocele.

(Reporter clarification.)

THE WITNESS: Yes. That's another term for rectocele.

MS. COTA: Q. But it's true we don't have any documentation similar to Dr. Allen's report where he talks about the number of fingers that he can insert?

A. That's correct.

MR. WES: Same objection.

MS. COTA: And is the -- whether or not -- well, strike that. I'm done.

THE WITNESS: Okay. That's all.

MR. WES: Do you have anything else? Go off the record for just a second.

(Discussion held off the record.)

MR. WES: We can go back on.

EXAMINATION BY MR. WES

MR. WES: Q. So just one very brief point of clarification. I think plaintiff's counsel asked you

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earlier if you were being compensated for your deposition testimony today. Is it true that you're being compensated for your time today?

A. Yes.

Q. Okay. And the opinions you're giving in this case are your opinions; is that right?

A. Absolutely.

MR. WES: Those are all the questions I have.

MR. JONES: Thanks, Doctor.

MR. WES: Standing order, rough and expedite.

MR. JONES: Rough for me and expedite.

MS. COTA: Same for me.

(Whereupon the deposition of TERI A. LONGACRE, M.D., was concluded at 12:55 p.m.)

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STATE OF CALIFORNIA,)
) ss.
COUNTY OF SANTA CLARA)

I, LISA R. KEELING, a Certified Shorthand Reporter in and for the State of California, hereby certify that the witness in the foregoing deposition, TERI A. LONGACRE, M.D., was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause, and that the foregoing is a full, true and correct transcript of the proceedings had at the taking of said deposition, reported to the best of my ability and transcribed under my direction.

Date ______________, 2014 ___________________________
LISA KEELING, CSR NO. 10518

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ACKNOWLEDGMENT OF DEPONENT

I,__________________________, do hereby certify that I have read the foregoing pages, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

____
TERI A. LONGACRE, M.D. DATE

Subscribed and sworn to before me on this ______day of_______________,20___, by ____________________
____,
proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature ________________________